Ear, Nose, and Throat
Medicine and Surgery Group
Aquidneck Hearing Center
STEVEN F. FREEDMAN

MIDDLETOWN COMMONS B-9

850 Aquidneck Avenue, Middletown, RI 02842
Telephone (401) 849-4448 *Fax* (401) 849-2709

BELLTOWER PLAZA

576 Metacom Avenue, Unit 6, Bristol, RI 02809

www.earnosethroatmed.com

PATIENT NAME:_____DATE OF BIRTH:_____

HOME ADDRESS:_____MALE/FEMALE:_____

CITY/TOWN:_____STATE:_____ZIP:_____

☐HOME PHONE:_____ ☐CELL PHONE:_____ ☐WORK PHONE:_____

****PLEASE CHECK PREFERRED NUMBER TO CALL****

E-MAIL ADDRESS:

PREFERRED LANGUAGE:_____ RACE/ETHNICITY:_____

IS THE PATIENT A STUDENT? YES/NO FULL / PART TIME IF SO, WHERE?_____

****

PLEASE FILL IN THE FOLLOWING IF PATIENT IS A CHILD OR STUDENT

MOTHER'S NAME:_____FATHER'S NAME:_____

DATE OF BIRTH:_____DATE OF BIRTH:_____

HOME ADDRESS:_____HOME ADDRESS:_____

CITY/STATE/ZIP:_____CITY/STATE/ZIP:_____

EMPLOYER:_____EMPLOYER:_____

OCCUPATION:_____FT/PT:_____OCCUPATION:_____FT/PT:_____

HOME P#_____WORK P#_____HOME P#_____WORK P#_____

CELL P#_____ CELL P#_____

****

PRIMARY CARE PHYSICIAN NAME:_____

PHYSICIAN REQUESTING THIS CONSULTATION:_____

PHARMACY NAME & TOWN:_____

HOW DID YOU HEAR ABOUT US? WEBSITE YELLOW PAGES FRIEND/RELATIVE
PCP HEALTH INSURER

MEDICAL INSURANCE COVERAGE INFORMATION

DO YOU HAVE MEDICARE? **YES** **NO** MEDICARE#:_____

IF SO, Do you or your spouse work? **YES** **NO**
IF SO, Does that employer provide health coverage for you? **YES** **NO**
IF SO, Please list name of employer: _____

DO YOU HAVE BLUE CROSS PLAN 65? **YES** **NO** B/C65#:_____

DO YOU HAVE STATE MEDICAID? **YES** **NO** MEDICAID#_____
****Our office does not participate with Medicaid, please initial that you understand there will be a co-insurance_____**

DO YOU HAVE COVERAGE THAT IS NOT LISTED ABOVE? **YES** **NO**

1. COVERAGE NAME AND ADDRESS:_____

_____

POLICY#:_____OFFICE VISIT COPAY:_____DEDUCTIBLE:_____

NAME OF SUBSCRIBER:_____SUBSCRIBER'S DOB: _____

SUBSCRIBER'S EMPLOYER:_____WORK PHONE#_____

2. NAME OF SECOND MEDICAL COVERAGE IF ANY:_____

_____

POLICY#:_____OFFICE VISIT COPAY:_____

NAME OF SUBSCRIBER:___SUBSCRIBER'S DOB: _____

SUBSCRIBER'S EMPLOYER:_____WORK PHONE#_____

****

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payors and/or other health care practitioners via letter, fax, or email. I also allow the physicians to check any electronic medical information pertaining to my health care including but not limited to prescriptions, x-rays, labs, and hospital records.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf where this may occur; Examples: insurance deductibles, co-pays and co-insurance.

I also give the physicians Dr. Dobbin and Dr. Freedman permission to treat myself and/or minor child and to communicate to me or my designated health care provider findings/results of my exam via letter, fax, email, or telephone.

SIGNED:_____DATE:_____