PDX ENT & AUDIOLOGY MEDICAL GROUP

Patient Information Form

Patient Name _____

Address _____ Apt# _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Birthdate _____ Marital Status _____ ☐ Male ☐ Female

Email Address _____

Preferred Language _____ Ethnicity & Race _____

INSURANCE INFORMATION: *Please present your card to the front receptionist. If no card is present, this office will consider your visit self-pay.*

Primary Insurance _____

Company _____ ID# _____ Group # _____

Secondary Insurance _____

Company _____ ID# _____ Group # _____

Please complete the following for both parents if patient is under age 26.

If patient insurance is through spouse/parent/guardian (father)

Name of Insured _____ DOB _____ Relationship to Insured _____

If patient insurance is through spouse/parent/guardian (mother)

Name of Insured _____ DOB _____ Relationship to Insured _____

THIS PORTION MUST BE COMPLETED IF YOU HAVE MEDICARE OR MEDICAID

If Medicare

☐ Traditional ☐ Providence ☐ UnitedHealth
☐ Familycare ☐ Healthnet ☐ CareOregon ☐ Other _____

If OHP

☐ CareOregon ☐ Familycare
☐ Providence ☐ Open Card ☐ Other _____

All co-payments and referrals are due at times of service as stated in your insurance contract. If no referral on file, you must pay for your visit. If self-pay, payment is due at time of service. If payments are needed, please consult the business office. I hereby authorize payment of medical benefits to Drs. Craig Hertler, Maxwell Furr, Patrick Radecki, Andrew K. Patel and/or Audiology. I authorize the release of any medical information necessary to process a claim. I acknowledge that I am financially responsible for all charges not covered by insurance, medicare or medicaid. Please read our patient information brochure. I have read and understand the above statements.

Signature _____ Date _____