Patient Information Form

PDX ENT & AUDIOLOGY MEDICAL GROUP

First Name _____ Middle Int. _____ Last_____

Date of Birth _____ Gender _____

Address _____ Apt#_____ City_____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____

Ok to leave confidential voicemail? ☐ Yes ☐ No Email Address _____

Preferred Language _____ Race _____

INSURANCE INFORMATION: Please present your card to the front receptionist. If no card is present, this office will consider your visit self-pay and will charge a cash pay price at the time of visit.

Primary Insurance _____

ID# _____ Group# _____ Company _____

Secondary Insurance _____

ID# _____ Group# _____ Company _____

If the patient is a minor or the insurance is through someone else other than themselves please specify the following

Name of Insured _____ *Birthdate* _____ *Relationship to Insured* _____

THIS PORTION MUST BE COMPLETED IF YOU HAVE MEDICARE OR MEDICAID

If Medicare:

☐ Traditional ☐ Providence ☐ United Heathcare ☐ Other _____

☐ Family Care ☐ HealthNet ☐ Care Oregon

If Medicaid (OHP):

☐ Care Oregon ☐ Family Care ☐ Other _____

☐ Providence ☐ Open Card

All co-payments and referrals are due at the time 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 Doctors Craig K. Hertler, Maxwell C. Furr, Andrew K. Patel, Patrick L. Radecki 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. I have read and understand the statements above.

Signature _____ Date: _____