[redacted]

PATIENT INFORMATION FORM

All patient information must be completed in full.

Please present your insurance card(s) to receptionist after completing form.

If you have insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle her/his account promptly. To help us file your insurance claim correctly we must make a photocopy of your insurance card. . All co-pay amounts must be paid at the time of the visit.

Patient Name		
Last	First	Middle
Sex:	**Birth Date:**	Married - Single -
Social Security #	**Email Address:**	
Address		Apartment #
City	**State:**	**Zip Code**
Home Phone:	**Cell Phone:**	
Work Phone:	Occupation:	
Place of Employment:	**Race:**	
Ethnicity: Hispanic - Non-Hispanic	**Primary Language Spoken:**	
Patient (Responsible Party) Signature:		Date:

INSURANCE INFORMATION

Primary Insurance Coverage	Insurance Co.	
Insured Name		**Birth Date:**
Home Address: (if different from patient)		
City	**State**	**Zip Code**
ID#	SS#	**Relationship to patient:**
Insured Place of Employment		
Business Address		
City	State	Zip Code
Secondary Insurance Coverage	Insurance Co.	
Insured Name		Birth Date
ID#	SS#	Relationship to patient:
Insured Place of Employment		
Business Address		
City	State	Zip Code

Pharmacy _____ Telephone _____

Address_____

Whom may we thank for referring you to our Clinic? _____

In case of emergency, who should be notified?_____Phone:_____

Preferred method to receive appointment reminders: Home Phone ☐ Cell Phone ☐ Text Message ☐

Baptist MEDICAL CLINIC | Ear, Nose & Throat

Date_____

Past Medical History

Yes	No	
		High blood pressure
		Diabetes
		Heart problems
		Asthma
		Emphysema (COPD)

Please list additional health problems of chronic illnesses:

Previous surgical procedures:

Yes	Social History
	Single
	Married
	Divorced
	Widowed
	Never smoked
	Current smoker; # packs per day_____
	Former smoker; years quit_____
	I do not drink alcohol
	2 or less alcoholic drinks per day
	More than 2 alcoholic drinks per day

Yes	Do your parents or siblings have the following conditions?			
	Allergies	Parents		Siblings
	Heart Disease	Parents		Siblings
	Cancer	Parents		Siblings
	Hearing loss	Left side		Right side
	Diabetes	Parents	Type 1	Type 2
		Siblings	Brother(s	Sister(s)

Other family medical problems:_____

_____

_____

_____

Please indicate any symptoms you currently experience:

Yes	No	
		Fever
		Cough
		Change in voice
		Difficulty swallowing
		Decreased hearing
		Lumps in neck
		Weight loss
		Visual loss
		Swelling in legs
		Shortness of breath
		List others:

Yes	No	
		Unusual bleeding
		Rash
		Vomiting
		Blood in urine
		Joint pain
		Heat or cold intolerance
		Seizures
		Chest pain
		Anxiety
		Depression
		List others:

Physician's Signature_____ Date_____

[redacted]

Medical Records Release Authorization
Baptist Ear, Nose & Throat - 601-973-1583
401 Baptist Dr., Ste 206
Madison, MS 39110

I hereby authorize the use of disclosure of my medical and health records and information about me described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. The released information may be re-disclosed to others who are not covered by federal privacy regulations, and the records and information may no longer be protected by federal privacy regulations. I also understand that I have the right to revoke this authorization in writing.

Patient Name: _____
S.S. Number: _____
Date of Birth: _____

I, _____, hereby authorize and request that you release the following information to:

(Request records **from** another facility/physician)

☐ Baptist Medical Clinic- ENT

_____

401 Baptist Dr., Ste 206
Madison, MS 39110
Phone: 601-973-1583
Fax: 601-973-1609

OR

(Request records **sent to** another facility/physician)

☐

_____

_____

I, _____, hereby authorize written or verbal communication concerning my care and request that you release the following information to: _____

Relationship to Patient:_____

Information to be released:

_____ Demographic _____ Lab _____ History

_____ X-ray _____ Discharge Summary _____ ER

_____ Consultations _____ Entire Record

Signature _____ Expires:_____
(If relative, state relationship)

Witness _____Date_____