

Account # _____

DALLAS OTOLARYNGOLOGY ASSOCIATES

Daniel M. Dansby, M. D.

B. Robert Peters, M. D.

REGISTRATION FORM

PATIENT MUST BE ACCOMPANIED BY AN ADULT IF UNDER 18

PATIENT INFORMATION:

Please print clearly Confidential Patient Information

Today's Date: 6/13/2004

Legal Name: _____ Age: _____ Birth Date: _____ Sex: M F

Social Security #: _____ Marital Status: S M W D Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

TX Drivers License: _____ Work Phone: _____

Employer: _____

E-Mail Address: _____

RESPONSIBLE PARTY INFORMATION (Policy Holder):

Legal Name: _____ Age: _____ Birth Date: _____ Sex: M F

Social Security #: _____ Marital Status: S M W D Separated

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

E-Mail address _____

SPOUSE OR SECOND PARENT INFORMATION:

Legal Name: _____ Age: _____ Birth Date: _____ Sex: M F

Social Security #: _____ Marital Status: S M W D Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer: _____

E-Mail address _____

NEAREST RELATIVE INFORMATION:

Legal Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

INSURANCE INFORMATION:

Primary Insurance Co.: _____ I.D.#: _____

Employer Group Name: _____ Group #: _____

Insurance Claims Address: _____

Insurance Phone #: _____

Subscriber's Name: _____ Relation to Patient: _____

Place of Employment: _____

Secondary Insurance Co.: _____ I.D. #: _____

Employer Group Name: _____ Group #: _____

Insurance Claims Address: _____

Insurance Phone #: _____

Subscriber's Name: _____ Relation to Patient: _____

Place of Employment: _____

PLEASE PROVIDE US WITH ALL YOUR INSURANCE CARDS INCLUDING MEDICARE SO THAT WE MAY MAKE A COPY FOR YOUR FILE.

Authorization to release information and assign benefits:

I hereby authorize the release of any medical information in the processing of my claim. I also authorize payment directly to Dr. Dansby or Dr. Peters and Associates for the medical / surgical benefits.

Signed: _____ Date: _____

DALLAS OTOLARYNGOLOGY ASSOCIATES
Ambulatory History

Today's Date _____

Patient Name _____ Birth Date _____ Age _____

Pharmacy Name _____ Phone # _____

Whom may we thank for referring you? _____

Referring Physician or Practitioner _____

Why are you here today? _____

How long have you had this problem? _____

Past Medical History:

Please list all medications you are presently taking, including over the counter, prescription, and any herbal medications _____

Allergies to Medications: No Yes Please List: _____

Allergic to Latex: No Yes Please List: _____

Previous Surgery: No Yes Please List: _____

Hospitalizations: No Yes Please List: _____

Tobacco (any form): No Yes Kind & Amount: _____

Alcohol: No Yes If yes, Occasional Moderate More than moderate

Review of Medical Systems (Explain briefly if you answer yes to any of the following problems)

Heart: No Yes Please Explain: _____

Kidney or Bladder: No Yes Please Explain: _____

Lung: No Yes Please Explain: _____

Neurological/Stroke: No Yes Please Explain: _____

Diabetes: No Yes Please Explain: _____

Thyroid: No Yes Please Explain: _____

High Blood Pressure: No Yes Please Explain: _____

Bleeding Problems: No Yes Please Explain: _____

Glaucoma: No Yes Please Explain: _____

Stomach, intestine, liver, or bowel: No Yes Please Explain: _____

Family History of bleeding problems: No Yes Please Explain: _____

Cancer of any form: No Yes Please Explain: _____

Any family history of problems with anesthesia: No Yes Please Explain: _____

FEMALES: Are you pregnant? Or suppose that you might be? No Yes

Patient Signature (Parent, if minor) _____ Relation to patient _____

Physician Signature _____ Date _____

DALLAS OTOLARYNGOLOGY ASSOCIATES

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign prior to any treatment. Dr. Dansby and Dr. Peters render only services that, in their best professional judgment, are needed to provide quality medical care for you.

PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, checks, Visa or MasterCard

REGARDING INSURANCE

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 45 days for your insurance company to pay your claim and if they do not we will give you 30 days to pay the balance.

- The patient is responsible to pay any deductible and co-payments at the time services are rendered.
- It is your responsibility to know if a referral is necessary for your visit.
- Any portion of a billed amount that is labeled “disallowed” or “not covered” will become the patient’s responsibility.
- Our office NEVER guarantees that your insurance will pay. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account.
- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. While we have an agreement with the Health Plan to provide services, any questions regarding coverage must be resolved by you with the insurance company.
- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s determination of usual and customary.

NSF CHECKS

All returned checks will be assessed a \$25.00 fee. All returned checks not paid in 15 days will be filed with the proper authorities.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the provisions of this financial policy.

Signature of patient or person responsible for the bill

Date