Currens Lane Melvin
Moore Rheney
Roberts Seal Audio

Asheville Head, Neck and Ear Surgeons, P.A.

Patient Profile

ID #: _____
(For office use only)

PATIENT INFORMATION

Legal Name: _____
First Middle Last

Preferred Name: _____ DOB: _____/_____/_____ Sex: M F SSN: _____-_____-_____

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

Preferred Contact #: _____ Cell / Home Alt Phone #: _____ Cell / Home / Work

I wish to receive my appointment reminders via (only circle one): PHONE TEXT E-MAIL

I authorize AHNE to leave messages on answering machine/voicemail of phone numbers listed above: YES NO

Employer: _____ Retired Unemployed Student Child

Marital Status: Married/Single/Divorced/Widow Language: _____ Race: _____ Ethnicity: _____

Email: _____*this will be used for the patient portal*

Emergency Contact: _____ Relationship to pt: _____

Emergency Contact Phone number: _____ Alt phone number: _____

PERSON RESPONSIBLE FOR PATIENT'S ACCOUNT (i.e. Guarantor, Parent, Guardian, etc.)

Legal Name: _____
First Middle Last

Relationship to patient: _____ DOB: _____/_____/_____ Sex: M F SSN: _____-_____-_____

Mailing Address: _____
City State Zip

Contact phone number: _____Cell/Home Alt phone number: _____Cell/Home/Work

Employer: _____ Retired Unemployed

PRIMARY INSURANCE

Subscriber's Name: _____
First Middle Last

Relationship to patient: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Insurance Company: _____ Employer: _____

SECONDARY INSURANCE ***Please list other insurance coverage on the back of this form*

Subscriber's Name: _____
First Middle Last

Relationship to patient: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Insurance Company: _____ Employer: _____

INSURANCE AUTHORIZATION

I authorize Asheville Head, Neck and Ear Surgeons, PA (AHNE) to release to the above named insurance company, to include Medicare, any information needed to process an insurance claim for myself or my dependent. I assign any payable benefits to AHNE. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____ Witness: _____

HIPAA CONFIDENTIALITY AGREEMENT *(Health Insurance Portability and Accountability Act)*

I authorize Asheville Head, Neck and Ear Surgeons, PA (AHNE) to render treatment to me or my dependent and provide Protected Health Information (PHI) for the purposes of carrying out treatment, obtaining payment, aiding in administrative operations, notifying referring offices, obtaining prior authorizations for prescriptions, and other entities (such as your pharmacy or Cover My Meds) that have a direct relationship in providing appropriate medical care to me or my dependent. I understand that by notifying AHNE, I have a right to restrict how my PHI is used. AHNE will consider these requests but may not agree with the restrictions requested. I hereby consent to the above use and disclosure of my PHI and understand that I may revoke this consent at any time. I have been offered a copy of AHNE's patient information policies.

Signature: _____ Date: _____ Witness: _____