Oakdale Ear Nose And Throat Clinic PA

3366 Oakdale Ave N Ste 150
Robbinsdale, MN 55422
(763) 520-7840

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	REFERRING PHYSICIAN	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

Referring Physician:______________________________

Primary Care Clinic & Location______________________________

Pharmacy:______________________________

______________________________ SIGNATURE OF PATIENT/GUARDIAN

______________ DATE

CLINIC CREDIT POLICY and PATIENT RESPONSIBILITY: If the patient is not covered by a health insurance plan, then he/she is responsible for payment at the time of service. Every insurance contract is different and benefits vary from policy to policy, therefore, the patient is responsible for knowing what is and what is not covered by his/her individual policy. If a patient has questions, he/she should refer to his/her insurance policy manual. If still unsure, the patient should contact the insurance company benefits department for clarification. Furthermore, in the event your account is referred to an outside agency for collection, you will be responsible for any collection costs and/or reasonable attorney fees that are incurred.

REFERRALS: If the patient's insurance provider requires a referral, it is the responsibility of the patient to obtain this **prior** to receiving care at Oakdale Ear, Nose & Throat Clinic.

CO-PAYMENTS: Co-payments are due at the time of service. A $5.00 service fee may be assessed to your account for co-payments not paid at time of service. Unpaid co-pays or fees may result in refusal of future services.

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance company to pay the proceeds of any benefits due me for services rendered by Oakdale Ear, Nose & Throat Clinic, P.A., directly to the provider. A copy of this form can be considered as an original for insurance purposes.

RELEASE OF INFORMATION: I authorize Oakdale Ear, Nose & Throat Clinic to release copies, or fax copies, including diagnoses and records of treatment concerning my medical records to insurance companies, referring physicians, hospitals or dental offices for the purpose of continuity of care or claim payment.

NOTICE OF PRIVACY PRACTICES: I have received the Notice of Privacy Practices.

CONSENT FOR TREATMENT: I voluntarily consent to diagnostic procedures and medical treatment by members of Oakdale Ear, Nose & Throat Clinic, P.A., as necessary in my physician's professional judgment. I am aware that the practice of medicine is not an exact science and acknowledge no guarantees can be made about the result of such treatment.

I have read, understand and agree to the above.

Signature of Patient ______________________________ **Date** ____________________

Or

Responsible Party ______________________________ **Relationship** ____________________

A copy of this form is available upon request.

REORDER # 0019645