Ear Consultants of Georgia, P.C.
Patient Information Update

Welcome! We are delighted to see you again. Please complete this update form for our records.

Date ____________________________ **Patient Account #** _____________________ **[Office Use Only]**

Name ____
First Middle Last

Address ____________________________________ City ____________________ State ______ Zip ____________

Home phone _____________________ Work phone ______________________ Other phone ______________________

Birthdate ___________ SSN ________________ Marital Status ____ Single ____ Married ____ Divorced ____ Widowed

Employer & Address ____

City ____ State _________________ Zip _____________

Responsible Party Name __________________________________ Relationship to Patient _________________________

Responsible Party SSN _____________________ Birthdate _________________ Phone # _________________________

Insured Party Name ________________________________ Insured Party SSN _______________________________

Insurance Company ________________________________ Insured Party Birthdate ___________________________

Have you had any medical problems since your last visit? _________ If so, please list.

____

List all current medications. ____

____

Are you allergic to any medications? ________ If so, please list.

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***** PLEASE PROVIDE YOUR CURRENT INSURANCE CARD(S) TO RECEPTIONIST. *****

Authorization & Release With this signature, I hereby authorize Ear Consultants of Georgia, P.C. to release any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. Furthermore, I understand that regardless of insurance, I am ultimately responsible for payment of fees for professional services rendered, including non-covered services. If my insurance company (ies) changes at any time, I am responsible to notify this office and provide a written copy or I will be ultimately responsible for payment of fees for professional services rendered at that time.

____ ____
Signature of patient (or parent or legal guardian) Date

Late Charges and Collections Fees All payments for services provided by this practice are due and payable at the time services are rendered, or within 30 days of the patient receiving the invoice for such services. In the event payment is not received as described above, a late payment fee of 1.5% per month will be charged. In addition, in the event that any bill goes to collection, patients will be charged all costs associated with collection, including reasonable attorney fees.

____ ____
Signature of patient (or parent or legal guardian) Date