

Mountain View Ear Nose & Throat, PC
112 Medical Circle, Winchester, VA 22601

Today's Date: _____

Patient Legal Name: _____

SS Number: _____ DOB: _____

Sex: Male/Female Marital Status: _____ Language: English/Spanish

Race: African American/Caucasian/Hispanic Ethnicity: Non-Hispanic/Hispanic

Home Phone: _____ Cell Phone: _____ Preferred #: Home/Cell

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email Address (Please Print): _____

Patient Employer: _____ Phone #: _____

Spouse/Significant Other Name: _____

Spouse/Significant Other DOB: _____ Phone #: _____

Emergency Contact: ***Please provide contact with a different phone number than the patient.***

Name: _____ Relationship: _____ Phone #: _____

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Please Complete & Provide Receptionist your Insurance Card and a Picture ID

Primary Insurance: _____ ID# _____

Policy Holder's Name: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ ID# _____

Policy Holder's Name: _____ SSN: _____ DOB: _____

Financial Policy/General Authorizations

I authorize treatment by the physician, resident physician, audiologist and/or nursing staff of **Mountain View Ear, Nose and Throat, PC** to provide medical procedures, treatment, including but not limited to, suctioning of ears, nose, throat and suture removal and any other routine services deemed necessary at the time of the office visit to the patient named on this form. I agree to pay all charges for such treatment. I understand that if I have insurance, and have provided accurate and complete information regarding my insurance, my charges will be filed with my carrier. The financial responsibility for services rendered to a patient, however, ultimately rests with the patient or responsible party. I understand that my co-pay and/or any coinsurance monies are due at the time of service. If I do not have insurance, or if charges are not to be filed with my insurance company, payment in full is due at the time services are rendered. In the event that this account becomes delinquent and is sent to our collection agency or an attorney, the responsible party agrees to pay all costs of collections including attorney fees and any and all costs involved with the legal collection of this debt.

I hereby authorize assignment and payment directly to **Mountain View Ear, Nose and Throat, PC** and medical benefits due me for services by them.

I acknowledge receipt of the Notice of Privacy Policies provided by **Mountain View Ear, Nose and Throat, PC**. I hereby authorize the practice to furnish to my insurance company or authorized agency, information regarding my protected health information, for the purpose of treatment, payments or health care operations. I further authorize the physician to consult as needed in their sole discretion with other medical providers regarding my medical care.

Mountain View Ear, Nose & Throat, PC can discuss my medical condition/information with the following person (s):
Please list all names and relationship to the patient:

***Please note, if a name is not listed above then NO information will be provided**

I understand that when paying by check to **Mountain View Ear, Nose and Throat, PC**, I will be responsible for a **\$25.00** fee if a check is returned. This does not include any other fees applied by your bank.

I have read and fully understand all the above insurance authorization/financial responsibilities, consent for treatment and release of medical information.

Patient's signature

Today's date

MOUNTAIN VIEW EAR, NOSE & THROAT, PC
112 Medical Circle, Winchester, VA 22601
Phone: (540) 542-1995/ Fax: (540) 542-1996

Authorization For Medical Treatment.

I _____ hereby authorize **Dr. Peter A. Johnson** and those whom he may designate as associates or assistants to perform upon the following medical treatment, Ear Cleaning.

The potential risk involved and possible consequences will be explained to me by Dr. Johnson or assistants. These include, but not limited to bleeding, infections, hearing loss, perforation of ear drum and pain.

Signature of Patient or Legal Guardian: _____

Witness: _____ **Date:** _____ **Time:** _____ **AM/PM**

MOUNTAIN VIEW

EAR, NOSE & THROAT, P.C.

Peter A Johnson, M.D.

112 Medical Circle, Winchester, VA 22601

Patient Name: _____ DOB: _____ Date: _____ Age: _____

PRIM. Phys.: _____ REF. Phys.: _____ Ht. _____ Wt. _____

Reason for today's office visit: _____

CURRENT MEDICAL CONDITIONS (Please Circle Yes or No):

Allergies	Yes	No	Heart Disease	Yes	No
Anxiety	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	High Cholesterol	Yes	No
Asthma	Yes	No	HIV: Pos/Neg	Yes	No
Bleeding Disorder	Yes	No	Hyperthyroid	Yes	No
Cancer	Yes	No	Hypothyroid	Yes	No
CPAP	Yes	No	Intestinal Disorder	Yes	No
Depression	Yes	No	Irregular Heart Beat	Yes	No
Diabetes: Type 1 or 2	Yes	No	Kidney Disorder	Yes	No
Emphysema	Yes	No	Liver Disorder	Yes	No
GERD	Yes	No	MRSA	Yes	No
Glaucoma	Yes	No	Pregnant	Yes	No
Headaches	Yes	No	Seizure Disorder	Yes	No
Hearing Loss	Yes	No	Sleep Apnea	Yes	No
Heart Attack	Yes	No	Stomach Ulcer	Yes	No
			Stroke	Yes	No

Family History of Hearing Loss? Yes No Family Member(s): _____

Family History of Cancer? Yes No Type: _____

Family Member(s): _____

Previous Surgeries: _____

Are you CURRENTLY taking any medications? Yes No

(If Yes, please list ALL medications you are currently taking, including over-the-counter medications, on the attached form)

ALLERGIES TO MEDICATIONS Yes No

If Yes, please list: _____

Active Smoker: Yes No

Chewing Tobacco: Yes No

Past Tobacco User: Yes No

Year Quit Tobacco: _____

Alcohol: Yes No

If Yes, circle: Social Daily Occasional

