Mountain View Ear Nose & Throat, PC

112 Medical Circle, Winchester, VA 22601 Phone: (540) 542-1995 Fax: (540) 542-1996

Today's Date:_____ Primary/Pediatrician Name:_____

Pharmacy:_____ Phone #:_____

Patient Legal Name:_____ SS Number_____

DOB:_____ Sex: Male/Female Language: English/Spanish

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

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

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Email Address:_____

Parent/Legal Guardian Information:

IF NOT BIOLOGICAL/NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT*

Please note: In cases of divorce with dependent children, the person bringing the child for treatment will be responsible for the bill

Mother/Step Mother/Legal Guardian *Name*:_____

SSN:_____ DOB:_____ Does Patient live with you?_____

Mailing Address (***if different than above***):_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____

Employer:_____ Phone Number:_____

Father/Step Father/Legal Guardian Name:_____

SSN:_____ DOB:_____ Does Patient live with you?_____

Mailing Address (***if different than above***):_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____

Employer:_____ Phone Number:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

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 direction 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.

This office is NOT a party to your divorce decree. The responsibility for minors rests with the accompanying adult. **A legal guardian must be present at each and every appointment unless the legal guardian provides this office with written authorization for someone else to make all necessary medical decisions on behalf of the minor patient.**

AUTHORIZATION TO BRING PATIENT TO OFFICE VISIT AND/OR FOR THE TREATMENT

If the legal mother and/or legal father are unable to bring the above named patient to the practice for an office visit and/or treatment, I herby authorize the following individuals to accompany my child and make healthcare decisions in my absence and I give consent for all medical treatment to be rendered. I understand that this authorization does not apply to bringing my child for surgery and that I must accompany my child to surgery.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

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

_____ _____

Signature of Parent, Foster parent, grandparent, legal guardian (circle one) **Today's Date**

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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 1or 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

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Patient Name:________________________________ DOB:____________________

Pharmacy Name & City:__________________________ Phone #____________________

Medications	MG/ Directions	Reason for Meds	Date	Date	Date	Date	Date