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**FLORIDA  
OTOLARYNGOLOGY  
GROUP, P.A.**

John F. Huhn, M.D., F.A.C.S.  
Gregory N. Boger, M.D.  
Richard F. Clark, P.A. - C.  
Denise L. Jackson, P.A. - C.

**PATIENT INFORMATION**

*Please Print*

Today's Date: \_\_\_\_\_ Patient Chart#: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Marital Status: M S W D Sep. \_\_\_\_\_

Telephone: Home#: \_\_\_\_\_ Business: \_\_\_\_\_ Patient's S.S.#: \_\_\_\_\_

Do you have an alternate address: Yes \_\_\_ No \_\_\_ If yes, please print here \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Husband (or Father): \_\_\_\_\_  
*Name S.S.# Birth Date*

\_\_\_\_\_ *Employed By Address Business Phone*

Wife (or Mother): \_\_\_\_\_  
*Name S.S.# Birth Date*

\_\_\_\_\_ *Employed By Address Business Phone*

Name of closest relative not living with you: \_\_\_\_\_  
*Relationship Telephone #*

**HEALTH INFORMATION**

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for seeing Doctor today: \_\_\_\_\_

**INSURANCE INFORMATION**

1st Insurance Co.: \_\_\_\_\_ 2nd Insurance Co.: \_\_\_\_\_

Policy Subscriber: \_\_\_\_\_ Policy Subscriber: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Telephone: \_\_\_\_\_ Insurance Telephone: \_\_\_\_\_

I.D. # \_\_\_\_\_ Group # \_\_\_\_\_ I.D. # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**As a courtesy, our practice will file your insurance claims. However, it is your responsibility to supply us with current and correct information and to know your policy requirements and limitations.**

**INSURANCE ASSIGNMENT**

I hereby authorize my insurance benefits to be paid directly to Florida Otolaryngology Group, P.A. or any of the physicians within the group. I realize I am responsible for paying any applicable co-pay, coinsurance, deductible or non-covered services.

Patient Signature: \_\_\_\_\_

**RELEASE OF MEDICAL RECORDS**

I hereby authorize the release of medical, psychiatric, alcohol, HIV testing and/or drug abuse information for insurance carriers or for continuing patient care.

Any of the classifications above may be crossed off if that information is not to be released.

Patient Signature: \_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY**

**MEDIGAP STATEMENT**

Health Insurance Claim Number: \_\_\_\_\_

Medigap Policy Number: \_\_\_\_\_

I request that payment of authorized Medigap benefits be made on my behalf to FLORIDA OTOLARYNGOLOGY GROUP, P.A. for any services furnished me by FLORIDA OTOLARYNGOLOGY GROUP, P.A.

I authorize any holder of medical information about me to release to (name of Medigap insurer) \_\_\_\_\_ any information needed to determine these benefits on the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

Signature of Beneficiary: \_\_\_\_\_ Today's Date \_\_\_\_\_

**MEDICARE PART B SIGNATURE AUTHORIZATION  
LIFETIME**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Medicare B # \_\_\_\_\_ Date: \_\_\_\_\_

**PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED**