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

John F. Huhn, M.D., F.A.C.S.
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Melissa A. Charnesky, D.O.
Richard F. Clark, 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#: _____ Cell#: _____ Patient's S.S.#: _____

Do you have an alternate address: Yes ___ No ___ If yes, please print here _____

Employer: _____ Work Phone #: _____

Husband (or Father, if a minor): _____

Name S.S. # Birth Date

Address Home Phone Alternate Phone

Wife (or Mother, if a minor): _____

Name S.S. # Birth Date

Address Home Phone Alternate 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 Holder: _____ Date of Birth _____ Policy Holder: _____ Date of Birth _____

Patient Relationship to the Policy Holder: _____ Patient Relationship to the Policy Holder: _____

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