STEVEN M. SHIMOURA M.D., P.A.

A DIVISION OF THE CENTERS FOR ADVANCED ENT CARE LLC

TO OUR PATIENTS: PLEASE FILL OUT THIS FORM IN ITS ENTIRETY FRONT AND BACK

PATIENT REGISTRATION:

Patient Name _____ **Social Security** _____
Street Address _____ **Date of Birth**_____**Age** _____
City/State/ZIP Code _____ **Marital Status** _____ **Sex** _____
Employer _____ **Employer Address**_____
Occupation _____ **City/State/ZIP Code**_____

CONTACT INFORMATION: *Please assist us by providing information where we can contact you*

Home # _____ **May we leave a message** **___Yes ___No**
Cell # _____ **May we leave a message** **___Yes ___No**
Work # _____ **May we leave a message** **___Yes ___No**

REFERRING PHYSICIAN/PRIMARY CARE PHYSICIAN:

Name_____ **Phone #**_____ **Fax #**_____

PREFERRED PHARMACY:

Name_____ **Phone #**_____ **Fax #**_____

PATIENT MEDICAL HISTORY:

___DIABETES **___THYROID DISEASE** **___HYPERTENSION**
___HEART DISEASE **___LIVER DISEASE** **___ASTHMA**
___ALCOHOL **___SMOKING____# OF PACKS PER DAY**

OTHER HISTORY:

_____

_____

ALLERGIES TO MEDICATIONS:

_____

_____

CURRENT MEDICATIONS:

_____

_____

INSURANCE INFORMATION: (MUST BE FILLED OUT COMPLETELY)

Primary Ins Co._____ **Secondary Ins. Co.**_____
Policy Holder Name_____ **Policy Holder Name**_____
Date of Birth_____ **Date of Birth**_____
Subscriber's Employer_____ **Subscriber's Employer**_____
City/State/ZIP Code_____ **City/State/ZIP Code**_____
Occupation_____ **Occupation**_____
Policy Number_____ **Policy Number**_____
Group Number_____ **Group Number**_____

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RESPONSIBLE PARTY OTHER THAN THE PATIENT IF UNDER 21

Guarantor Name_____ **Social Security #**_____
Street Address_____ **Home Phone** _____
City/State/ZIP Code_____ **Work Phone** _____

FEDERAL LAW ACKNOWLEDGES PERSON 18 YEARS OLD TO BE AN ADULT AND, THEREFORE, RESPONSIBLE FOR THEIR OBLIGATIONS. IN THE UNFORTUANTE EVENT COLLECTIONS PROCEDURES ARE REQUIRED TO COLLECT AN OUTSTANDING BALANCE, THE PATIENT SHALL BE RESPONSIBLE FOR THE ADDITIONAL COSTS (100% OF THE PAST DUE BALANCE) OF A COLLECTION AGENCY, ATTORNEY, AND/OR COURT COSTS. UNPAID BALANCES OF 90 DAYS OR MORE WILL BE SENT TO COLLECTIONS.
I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY, AND CERTIFY THAT I AM THE PATIENT, OR DULY AUTHORIZED GENERAL AGENT OF THE PATIENT, AUTHORIZED TO FURNISH THE INFORMATION REQUESTED. I CERTIFY THAT THE INFORMATION I HAVE REPORTED IS CORRECT. I UNDERSTAND THAT EVEN THOUGH I HAVE SOME TYPE OF INSURANCE, I AM RESPONSIBLE FOR UPDATING THE PRACTICE WITH ANY CHANGES TO THE INFORMATION ABOVE.
RELEASE OF INFORMATION/AUTHORIZATION TO FILE: AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS A CLAIM AND HEREBY AUTHORIZE Steven M. Shimoura, M.D., P.A. TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

NO SHOW AND CANCELLATION POLICY:

Our practice policy as of August 1, 2006 states that we will charge a $35 fee for any missed appointments not cancelled with 24 hours notice. If you choose to cancel your appointment after hours, you may leave a message with our answering service. Please sign and date below showing that you understand this policy.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

HIPPA:

I have received and reviewed a copy of HIPPA compliant privacy practices for the office of Steven M. Shimoura M.D., P.A., a division of The Centers For Advanced ENT Care.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

I give permission for the following person/persons to speak with the above listed practice in regards to my medical information including treatment and medical billing.

Name_____ Relationship_____ Phone #_____
Name_____ Relationship_____ Phone #_____
Name_____ Relationship_____ Phone #_____
Name_____ Relationship_____ Phone #_____

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

EMERGENCY CONTACT: *please list one person that may be contacted incase of an emergency*

Name_____ Relationship_____ Phone #_____