

TODAY'S DATE \_\_\_\_\_



Maxwell, Knowland, and Kluger, ENT Associates, MD, PA

**ADULT PATIENT INFORMATION**

WHICH OF OUR LOCATIONS ARE YOU GOING TO? (circle one)		PORTLAND		BIDDEFORD	
WHICH OF OUR PROVIDERS ARE YOU GOING TO SEE? (circle one)		Dr. Maxwell		Dr. Knowland	
		Dr. Kluger		Dr. Friberg	
		Dr. Makaretz		An Audiologist	
Patient Name:		Age:		DOB:	
Street Address:		City:		State:	
ZIP:		Home Tel:		Work Tel w/ext:	
Social Sec. #		Employer:		Occupation:	
Emp. Address:		City:		State:	
ZIP:		Spouse Name:		Age:	
DOB:		Street Address:		City:	
State:		ZIP:		Social Security # (if available)	
Home Tel (if available):		Work Tel w/ext (if available):		EMERGENCY CONTACT:	
EMERGENCY TELEPHONE:		LIST DRUG ALLERGIES:			
WHY ARE YOU BEING SEEN?					
DUE TO AN ACCIDENT?		YES		NO	
		IF YES, DATE OF ACC.:			
REFERRING PHYSICIAN: _____			PRIMARY CARE PHYSICIAN: _____		
I authorize release of medical information to my Referring and Primary Care Physician.					
Patient Signature: _____					
CURRENT MEDICATIONS (prescription/non-prescription)					
HAVE YOU HAD OR ARE YOU BEING TREATED FOR ANY OF THE FOLLOWING?: (Please Circle)					
Heart Disease?		YES		NO	
Diabetes?		YES		NO	
Bleeding Problems?		YES		NO	
High blood pressure?		YES		NO	
Infections?		YES		NO	
Stroke?		YES		NO	
Cancer?		YES		NO	
Thyroid disease?		YES		NO	
Other?		YES		NO	
Explain all YES answers from above. Include type of Cancer and location.					
Hospitalizations and Surgeries					
Reason:		Year:		Hospital:	
Reason:		Year:		Hospital:	
Reason:		Year:		Hospital:	
Reason:		Year:		Hospital:	
Do you smoke?		YES		NO	
Drink Alcohol?		YES		NO	
Ever smoked?		YES		NO	
Recreational Drugs?		YES		NO	
Family History					
Do you have a Family history of:					
Heart Disease?		YES		NO	
Diabetes?		YES		NO	
Bleeding Problems?		YES		NO	
High blood pressure?		YES		NO	
Infections?		YES		NO	
Anesthesia Problems?		YES		NO	
Cancer?		YES		NO	
Thyroid disease?		YES		NO	
Stroke?		YES		NO	
Explain all YES answers from above. Include type of Cancer and location.					
Your Father?		ALIVE		DECEASED	
Cause of Death?					
Your Mother?		ALIVE		DECEASED	
Cause of Death?					
Your Siblings?		ALIVE		DECEASED	
Cause of Death?					
Your Children?		ALIVE		DECEASED	
Serious Illness or cause of Death?					

Reviewed by Physician: \_\_\_\_\_

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

**MORE INFORMATION REQUESTED ON OTHER SIDE OF THIS FORM, PLEASE TURN OVER AND COMPLETE**

Is there insurance coverage available for the patient being seen? YES NO

If no, who is responsible for paying for these medical services?

First Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Relation to Patient: (Circle one) SELF SPOUSE PARENT GUARDIAN OTHER

If yes, who is the insured person? (also known as the subscriber or guarantor)

First Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Relation to Patient: (Circle one) SELF SPOUSE PARENT GUARDIAN OTHER

If yes, what is the name of the insurance plan? Please check one or more below. If your coverage is not listed, please add.

- Aetna Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_
- Anthem (BC/BS) Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_
- Cigna/Healthsource Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_
- Harvard Community HealthPlan Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_
- Maine Partners Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_
- Medicaid Medicaid # \_\_\_\_\_
- Medicare Medicare # \_\_\_\_\_
- Other: \_\_\_\_\_ Group #: \_\_\_\_\_ Certificate #: \_\_\_\_\_

Co. Name:	_____
Address:	_____
City, State, Zip	_____

### Payment Agreement

All professional services rendered are the ultimate responsibility of the patient. If your insurance company will be taking care of all or a portion of your bill, your signature on the agreement below will expedite your claim.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Maxwell, Knowland, and Kluger, ENT Associates, MD, PA for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration, insurance carrier or other medical pyhysicians and authorized agents of the afore mentioned entities any information needed to determine these benefits payable for the related services. I understand that any portion of the bill that Insurance does not cover is my responsibility. If my insurance plan requires a referral for today's visit, I acknowledge that I am aware that my insurance plan may reduce the amount paid or deny payment because the necessary referral was not obtained or was obtained too late. I have been given the opportunity to reschedule this appointment but I elect to receive services today with the knowledge of reduced or denied benefis and that I am responsible for payment

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relation to Patient: SELF SPOUSE PARENT GUARDIAN