TODAY'S DATE__________________

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

PEDIATRIC 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:
Social Sec. #		Home Tel:		Work Tel. w/ext			
Mother's Name:				Age:		DOB:	
Street Address:		City:			State:		ZIP:
Social Sec. #		Home Tel:		Work Tel. w/ext			
Father's Name:				Age:		DOB:	
Street Address:		City:			State:		ZIP:
Social Sec. #		Home Tel:		Work Tel. w/ext			
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 Siganture:**____

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.

	Plan	Number	Certificate
☐	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