DRS. GEHRIS, JORDAN, DAY AND ASSOCIATES, LLC

Head and Neck Surgery • Ear, Nose and Throat Surgery • Facial Plastic & Reconstructive Surgery

New Patient Information Form

❑ MR. ❑ MISS ❑ MALE Date ____________________________
❑ MRS. ❑ MS. ❑ FEMALE

PATIENT IDENTIFICATION – Please Print

PATIENTS LAST NAME		FIRST		MIDDLE
AGE	DATE OF BIRTH	STREET ADDRESS		APT. NO.
CITY	STATE	ZIP CODE		SOCIAL SECURITY NUMBER
HOME PHONE	BUSINESS PHONE	MARITAL STATUS: ❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ SEPARATED ❑ WIDOWED		
PATIENTS OCCUPATION	EMPLOYER'S NAME	ADDRESS		
EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	TELEPHONE NUMBER		
FAMILY PHYSICIAN	ADDRESS	PHONE		
ALLERGIES				

GUARANTOR – (if under 18)

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT
ADDRESS	CITY	STATE	ZIP CODE	
HOME PHONE	BUSINESS PHONE	EMPLOYER	ADDRESS	

PRIMARY INSURANCE – Please present your insurance card to the receptionist.

NAME OF INSURANCE COMPANY		ADDRESS			
POLICY OR CERTIFICATE NO.	GROUP NO.	EFFECTIVE DATE / /	POLICY HOLDERS NAME	SEX	DOB / /
PATIENTS RELATION TO INSURED	SUBSCRIBER'S EMPLOYER	WORK PHONE	HOME PHONE		

SECONDARY INSURANCE – Please present your insurance card to the receptionist.

NAME OF INSURANCE COMPANY		ADDRESS			
POLICY OR CERTIFICATE NO.	GROUP NO.	EFFECTIVE DATE / /	POLICY HOLDERS NAME	SEX	DOB / /
PATIENTS RELATION TO INSURED	SUBSCRIBER'S EMPLOYER	WORK PHONE	HOME PHONE		

I, ______________________________, hereby authorize Drs. Gehris, Jordan, Day & Associates, LLC to apply for benefits on my behalf for covered services rendered. I request payment from Blue Shield of Maryland, Medicare and or ________________________________ be made directly to Drs. Gehris, Jordan, Day & Associates.
other ins. co. name

I Certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above billing agent, Blue Shield of Maryland (or in case of Medicare Part B benefits, to the Society Security Administration and Healthcare Financing Administration).
and/or ___________________________________, I permit a copy of this authorization to be used in place of original. This authorization may
other ins. co. name
be revoked by either me or above named carrier at any time in writing.

I consent to the treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring family physicians and to my insurance company if applicable.

I understand that payment of charges incurred is due at the time of services unless other definite financial arrangements have been made prior to treatment.

I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

PATIENT CHART NUMBER

______________________________ ______________________________
Date Signature