PATIENT INFORMATION:

PATIENT'S NAME____ SOCIAL SECURITY NUMBER_________________________
ADDRESS____ DATE OF BIRTH___________________________________
CITY________________________ STATE________ ZIP______________ PREFERRED PHONE_______________________________
PLEASE PROVIDE YOUR E-MAIL ADDRESS IF YOU WOULD LIKE TO VIEW YOUR MEDICAL RECORDS ONLINE.
E-MAIL ADDRESS ____. ALTERNATIVE PHONE NUMBER____________________
OK TO E-MAIL YOU WITH COSMETIC SPECIALS? □ YES □ NO PHARMACY NAME/LOCATION________________________________

RACE:
_____WHITE _____AMERICAN INDIAN/ALASKA NATIVE _____ASIAN _____BLACK OR AFRICAN AMERICAN
_____NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER _____REFUSE TO REPORT/UNREPORTED

EMPLOYER INFORMATION
EMPLOYER'S NAME____ MAY WE CONTACT YOU AT WORK? _____YES _____NO
WORK NUMBER____

PRIMARY INSURANCE HOLDER IF OTHER THAN SELF
NAME________________________________ RELATIONSHIP TO PATIENT____________________ DATE OF BIRTH_______________

COMPLETE ONLY IF PATIENT IS A MINOR
MOTHER'S NAME_______________________________________ MAY WE CONTACT YOU AT WORK? _____YES _____NO
WORK NUMBER____
FATHER'S NAME_______________________________________ MAY WE CONTACT YOU AT WORK? _____YES _____NO
WORK NUMBER____________________________________
WHO DOES CHILD RESIDE WITH: _____MOTHER _____FATHER _____BOTH

PLEASE LIST THE NAME AND ADDRESS OF THE INDIVIDUAL RESPONSIBLE FOR THE BILL:
____
____

EMERGENCY CONTACT INFORMATION
EMERGENCY CONTACT____ PHONE__________________________________
RELATIONSHIP____
HOW DID YOU HEAR ABOUT DR. YAISH? _____PHYSICIAN _____FAMILY/FRIEND _____INTERNET _____OTHER
WHO IS YOUR PRIMARY PHYSICIAN? _______________________________________ LOCATION___________________________________
IF YOU WERE REFERRED HERE PLEASE LIST NAME____
PLEASE LIST ANY OTHER FAMILY MEMBERS SEEN BY DR. YAISH____

IF I AM NOT AVAILABLE I GIVE MY PERMISSION FOR YOUR OFFICE TO LEAVE A MESSAGE AT MY PREFERRED NUMBER WHEN MAKING REMINDER CALLS FOR APPOINTMENT DATES AND TIMES. _____YES _____NO

PATIENT OR AUTHORIZED PERSON'S SIGNATURE
I AUTHORIZE A. DANNY YAISH D.O. TO RELEASE/ RECEIVE ANY MEDICAL OR INCIDENTAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATIONS FOR FINANCIAL BENEFITS. I AUTHORIZE DIRECT PAYMENT OF BENEFITS TO A. DANNY YAISH D.O. FOR SERVICES AND/OR HOME MEDICAL EQUIPMENT & SUPPLIES RENDERED BY HIM OR OTHERS UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THESE CHARGES AND/OR ANY BALANCE NOT COVERED BY MY INSURANCE. ***AFTER YOUR 2ND NO SHOW/NO CALL, YOUR ACCOUNT WILL BE CHARGED $25.00 AND POTENTIALLY YOU MAY BE DISCHARGED FROM PRACTICE.*** I HAVE READ THIS AGREEMENT AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

PATIENT/AUTHORIZED PERSON'S SIGNATURE____
PRINT NAME____ DATE____
RELATIONSHIP TO PATIENT____

It is the responsibility of the insured to verify that Dr. Yaish is within network with his/her insurance plan. If Dr. Yaish is not with his/her plan, the total balance for charges incurred is the responsibility of the insured and is to be paid in full within 30 days of receiving first statement.

PLEASE SEE REVERSE FOR FURTHER INFORMATION

ADDITIONAL INFORMATION REGARDING DISCLOSURE
OF PATIENT MEDICAL INFORMATION

Ear, Nose, Throat & Plastic Surgery Specialists honor a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Sending Authorizations to Ear, Nose, Throat & Plastic Surgery Specialists: If mailing an authorization, please mail to:
Ear, Nose, Throat & Plastic Surgery Specialists
120 Park Avenue
Beaver Dam, WI 53916

Verbal Communication Only. This authorization allows for verbal communication between Ear, Nose, Throat & Plastic Surgery Specialist and the designated person on this form. It does not allow for copies of medical records to be released.

No Obligation to Sign. You are not under any obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, Ear, Nose, Throat & Plastic Surgery Specialists providers may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:
Ear, Nose, Throat & Plastic Surgery Specialists
120 Park Avenue
Beaver Dam, WI 53916

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical Information without your prior permission.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact:

Ear, Nose, Throat & Plastic Surgery Specialists
120 Park Avenue
Beaver Dam, WI 53916

Voice Mail Messages. Ear, Nose, Throat & Plastic Surgery Specialists providers and their staff recognize confidentiality as a very important part or your relationship with them. To protect your confidentiality, they will not routinely leave messages on your personal messaging system (voice mail or answering machine or with your spouse, family members or any other individual) unless you specifically give your permission to do so. This authorization may be used to share this information in the manner that you specify.