Upper Valley ENT & Allergy – Jay McMaster D.O. – Barry Peterson, D.O. – Dan Weber, PA-C

256 North 2nd East Rexburg, ID 83440 – ph: (208) 656-9646 – fax: (208) 656-9645 – www.uventallergy.com

PATIENT NAME:_____ DATE OF BIRTH ____/____/____
Last First Middle Initial Month/Day/Year

FEMALE ☐ MALE ☐ MARITAL STATUS: M ☐ S ☐ W ☐ D ☐ SOCIAL SECURITY NUMBER (Optional)_____

STREET ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

MAILING ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

EMPLOYER:_____ OCCUPATION:_____

EMAIL ADDRESS:_____

PHARMACY:_____

RACE:
- ☐ AMERICAN INDIAN
- ☐ ASIAN
- ☐ BLACK/AFRICAN AMERICAN
- ☐ HISPANIC
- ☐ NATIVE HAWAIIN/OTHER PACIFIC
- ☐ OTHER _____
- ☐ WHITE
- ☐ REFUSE TO ANSWER

ETHNICITY:
- ☐ HISPANIC/LATINO
- ☐ NOT HISPANIC/LATINO
- ☐ REFUSE TO ANSWER

STUDENT STATUS:
- ☐ FULL TIME
- ☐ PART TIME
- ☐ NOT A STUDENT

PREFERRED LANGUAGE:
- ☐ ENGLISH
- ☐ OTHER _____
- ☐ SPANISH
- ☐ REFUSE TO ANSWER

TRANSLATOR NEEDED?
YES ☐ NO ☐

RESPONSIBLE PARTY:

NAME:_____ RELATIONSHIP:_____ BIRTHDATE: _____

ADDRESS:_____ PHONE NUMBER:_____

Is this person authorized to receive medical information on your behalf? YES ☐ NO ☐

EMERGENCY CONTACT:

NAME:_____ RELATIONSHIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL:_____

Is this person authorized to receive medical information on your behalf? YES ☐ NO ☐

PRIMARY INSURANCE:_____ POLICY NUMBER:_____

GROUP NUMBER:_____ POLICY HOLDER SSN:_____

POLICY HOLDER'S NAME:_____ **POLICY HOLDER DOB**: _____

SECONDARY INSURANCE:_____ POLICY NUMBER:_____

GROUP NUMBER:_____ POLICY HOLDER SSN:_____

POLICY HOLDER'S NAME:_____ **POLICY HOLDER DOB**: _____

FAMILY PHYSICIAN:_____ OFFICE PHONE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

REFERRING PHYSICIAN:_____ OFFICE PHONE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

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HOW DID YOU FIND US?

- ☐ Friend/Family
- ☐ Physician Referral
- ☐ Commercial
- ☐ Phonebook
- ☐ Ad
- ☐ Sign on Street
- ☐ Internet
- ☐ Other _____

I certify that any and all information in any form is truthful and correct to the best of my knowledge. If I learn that any such information that has been submitted was not correct, I agree to notify Upper Valley ENT & Allergy of this immediately.

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT OF UPPER VALLEY ENT & ALLERGY NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Upper Valley ENT & Allergy's Notice of Privacy Practices.

_____	_____	_____
Signature	Relationship to Patient	Date

UPPER VALLEY ENT & ALLERGY USE ONLY:

Acknowledgement received by: _____

WORKMAN'S COMPENSATION INFORMATION (if required)

DATE / TIME OF INJURY: _____/_____ WORK RELATED? Y N

CAUSE: _____ REFERRED BY: _____

WORKMAN'S COMP. CARRIER: _____

Please note:

In addition to your office visit, you may receive a bill for the following services:

CT Scan
Lab work
Pathology
Procedures
Scopes (nasal and oral)