

ALASKA FAMILY ENT - DAVID S. KILLEBREW, M.D. FACS
Reconstructive Surgery, Head & Neck Surgery, Facial, Plastic, Trauma & Maxillofacial Surgery, Otolologic

Patient Information (Please Print)

Name: _____ Sex: ___ M ___ F Age: _____
Address: _____ Date of Birth: ____/____/_____
City, State, Zip: _____ Social Security Number: _____-_____-_____
Home Phone: _____-_____-_____
Work Phone: _____-_____-_____ Married ___/ Single ___/ Divorced ___/ Widow ___
Cell Phone: _____-_____-_____

Emergency Contact

Name	Relationship	Phone
_____ Last First	_____	_____-_____-_____

Primary Physician: _____ **Referring Physician:** _____

Were you seen at an Emergency Room or Urgent Care? (Providence ___) (Alaska Regional ___) Other ___
When were you seen? ____/____/_____

Patient Employment Information

Employed ___/Retired ___/Unemployed ___/Self ___/Minor _____
Occupation: _____
Name of Work/School: _____

Responsible Party/Guardian (For patients under 18 years)

Name: _____	Home Phone: _____-_____-_____
Address: _____	Work Phone: _____-_____-_____
City, State, Zip: _____	Social Security Number: _____-_____-_____ Date of Birth: ____/____/_____
Employer: _____	Relationship: _____

INSURANCE

Primary Insurance/Worker's Compensation

Insurance Name: _____
ID #: _____ Group#: _____
Subscriber Name: _____
Subscriber SS#: _____-_____-_____
Subscriber DOB: ____/____/_____
Subscriber Phone: _____-_____-_____
Relationship to Patient: _____
Subscriber Employer: _____

Secondary Insurance

Insurance Name: _____
ID #: _____ Group#: _____
Subscriber Name: _____
Subscriber SS#: _____-_____-_____
Subscriber DOB: ____/____/_____
Subscriber Phone: _____-_____-_____
Relationship to Patient: _____
Subscriber Employer: _____

I hereby certify the above information is true and correct to the best of my knowledge. I give consent for medical examination and treatment. I further authorize Dr. Killebrew to release to any insurance company, which has issued medical or hospitalization insurance, all information regarding any treatment by said doctor. I assign direct payment to Dr. Killebrew: all medical and surgical benefits payable due for services provided and cause for action for the collection of said benefits. Payment is required at the time of service unless other arrangements have been made.

Signature patient/guardian: _____ **Date:** _____

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This notice is effective as of _____
Date

I have read/or been offered the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Alaska Family ENT with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's Signature

Authorized Facility Signature

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OUR FINANCIAL POLICY INCLUDES THE FOLLOWING:

You as the patient are responsible for payment of the account regardless of insurance coverage. Insurance is a contract between you and your insurance company. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office can not accept responsibility for collecting a settlement on a disputed claim. You are responsible for payment on deductibles, co-payments, disputed or denied claims, as well as the portion not covered under the terms of your individual policy. In order to bill your insurance(s) we do require a copy of the issued card(s). If no card is provided then the patient or guardian is responsible for filing any claims.

For patients requiring surgery, we will contact the insurance carrier for medical benefits and pre-authorizations. This does not guarantee payment of benefits. It is the insured's responsibility to know his/her policy for any pre-existing exclusions, waiting periods, and/or waivers placed on his/her policy. If a claim is denied we will assist you in furnishing any information that pertains to this office.

All accounts are expected to be paid in full within 60 days of receipt of your statement unless other arrangements have been made with our office. If you are unable to pay your account balance in full within this time, please call our office, 278-1016, as soon as possible to make payment arrangements.

I understand that if my bill is past due it will be sent to collections, Cornerstone Credit Services, and I will not only be responsible for the original amount owed but also for the cost of collection due to the balance being forwarded to a collection agency.

I authorize the release of information in my medical history to Medicare/Medicaid and/or my insurance (s) and assign all benefits for unpaid services to Dr. Killebrew.

I understand that I am financially responsible for those charges not paid by my insurance. A photo copy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

_____ **Date** _____
Patient/Legal Guardian

Name _____

Date _____

PAST MEDICAL HISTORY

For the safety of Dr. Killebrew and his staff please inform us of any infectious diseases that you may have. Please keep in mind that all information is kept confidential and your standard of care will not be affected by the information that you have disclosed to our office.

Medical Illnesses: Do you have any of the following diseases: (Circle)

High blood Pressure Diabetes Asthma Cancer Thyroid disease

Hepatitis _____ Cirrhosis Seizures HIV Tuberculosis

Other: _____

(1) Bleeding Tendency? Yes No If Yes, Please explain: _____

(2) Have you ever received a blood transfusion? Yes No Year _____

(3) Trauma: Any head Injuries? Yes No Year _____

(4) Loss of consciousness? Yes No

(5) Have you ever had your hearing tested? Yes No Year _____ Location _____

Family Medical History (any medical conditions ONLY, no names please)

Father: _____

Mother: _____

Brother/Sister: _____

Son/Daughter: _____

Is there anything else you wish Dr. Killebrew to know about your health or medical history?

On a regular basis

Do you have difficulty breathing through your nose? (Circle one)

No/Rarely Occasionally Usually/Always

Does your nose get congested when you lie down or while you are sleeping? (Circle one)

No/Rarely Occasionally Usually/Always

Do you use nasal medications such as over-the-counter and/or prescription nasal sprays or decongestants? (Circle one)

No/Rarely Occasionally Usually/Always