Patient Information

Today's Date

Last Name | First Name | Middle initial | Nickname / AKA

Date of Birth | Social Security Number | Gender

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Marital Status

Employer

Mailing Address | Apt # | City | State | Zip

☐ Home Phone ☐ Work Phone ☐ Cellphone
Please mark and fill in you preferred primary phone

Email Address ☐ Permission to communicate by email

Responsible Party / Guarantor Information

Who is the responsible party / guarantor? ☐ Self / Patient ☐ Other (complete below)

Last Name | First Name | Middle initial | Date of Birth

Home Address | Apt # | City | State | Zip

☐ Home Phone ☐ Work Phone ☐ Cellphone | Email Address

Relationship to Patient | Divers License # & State (required)

Emergency Contact | **Phone**

Physician Referral Information

Primary Care Physician Name | Primary Care Physician Phone #

Referring Care Physician Name | Referring Care Physician Phone #

Pharmacy Information

Pharmacy Name | Pharmacy Address | Pharmacy Phone # | Pharmacy Fax #

Patient Insurance Form

Note: Please make sure you provide us a copy of each insurance card. if your insurance changes, please let us know so we can update your records.

Patient Information

Last Name | First Name | Middle initial | Nickname / AKA

First (Primary) Insurance Information

Insurance Company Name | Insurance Holder Name | Date of Birth | Employer Name

Policy # | Group #

Home Address (if different than patient's) | Apt # | City | State | Zip

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Second (Secondary) Insurance Information

Insurance Company Name | Insurance Holder Name | Date of Birth | Employer Name

Policy # | Group #

Home Address (if different than patient's) | Apt # | City | State | Zip

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other

Assignment Of Benefits: I hereby assign all medical benefits to which I might be entitled, including Medicare, Medicaid, Private Insurance or Worker's Compensation (this list is not all inclusive) to KImi Dart, D.O., PLLC for services provided to myself and/or my dependents and not yet paid in full. I hereby authorize and direct my insurance carrier to issue payment directly to the provider listed. A photocopy of this assignment is to be considered as valid as the original.

Signature of Patient/Legal Guardian | Date

Patient Consent Form

Please review the statements below and initial where indicated.

Last Name | First Name | Middle initial | Date of Birth

Consent to Evaluate and Treat

I authorize Kimi Dart, D.O. to evaluate and provide treatment for my otolaryngology and/or allergy needs, as well as those of my auditory system. This may include medical management of a variety of ear, nose and throat disorders; comprehensive audiometry threshold evaluation and speech recognition; tympanometry; acoustic refl ex testing, or allergy treatment.

Initials _____

HIPAA Consent (copies of the law available upon request)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out treatment and/or billing, or where applicable by law.

Initials _____

I give permission for **Kimi Dart, D.O., PLLC** to release upon request information (medical, financia l and/or appointment) to the following individual(s):

Name of Person _____ Relationship _____

Name of Person _____ Relationship _____

Consent for Medical Photography

I agree to have photographs taken in the course of 1) pre-operative evaluation and planning; 2) intra-operative or procedural documentation or evaluation; or 3) post-operative documentation or evaluation. The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Initials _____

Authorization to Include in Educational and/or Marketing Outreach

Authorizing marketing communication from this practice means I may:

A. Receive communication concerning treatment alternatives or other health-related products or services.

Marketing Authorization Options:

- ☐ I wish to receive Marketing Communications from this Practice Only
- ☐ I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates
- ☐ I **DO NOT** wish to receive **ANY** Marketing Communications **Initials** _____

Your information will never be released or sold to any outside entity. Any other release of your Protected Health Information requires a signed HIPAA release form. You may opt out of future educational/marketing outreach by writing to us at:

215 Oak Drive South, Suite E, Lake Jackson, TX 77566

Patient Signature _____ Date _____