EAR, NOSE & THROAT OF FREEHOLD, LLC

MARK ROESSLER, D.O., F.A.O.C.O.

PATIENT INFORMATION

NAME	BIRTH DATE	AGE	SOCIAL SECURITY #	MARITAL STATUS (circle one) S M D W SEP
STREET ADDRESS				SEX MALE FEMALE
				HOME PHONE # ( )
CITY	STATE	ZIP CODE		CELL PHONE # ( )
OCCUPATION / EMPLOYER				BUSINESS PHONE # ( )
EMERGENCY CONTACT	EMERGENCY CONTACT'S OCCUPATION/EMPLOYER			EMERGENCY CONTACT'S PHONE # ( )
EMAIL ADDRESS				RACE
PERSON RESPONSIBLE FOR PAYMENT, IF OTHER THAN PATIENT				
STREET ADDRESS				HOME PHONE # ( )
				CELL PHONE # ( )
CITY	STATE	ZIP CODE		BUSINESS PHONE # ( )
HAVE YOU BEEN TREATED BY OUR PHYSICIANS WITHIN THE LAST 3 YEARS? ☐ Yes / ☐ No				
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIANS? ☐ Yes / ☐ No				
PRIMARY CARE PHYSICIAN NAME / ADDRESS				OFFICE PHONE # ( )
PHARMACY				PHARMACY PHONE # ( )

INSURANCE INFORMATION (Please provide insurance card to receptionist so that we can make copies for our records)

PRIMARY INSURANCE COMPANY			
CARDHOLDER'S NAME		RELATIONSHIP TO CARDHOLDER	
CARDHOLDER'S BIRTH DATE	SOCIAL SECURITY #	ID #	GROUP #
SECONDARY INSURANCE COMPANY			
CARDHOLDER'S NAME		RELATIONSHIP TO CARDHOLDER	
CARDHOLDER'S BIRTH DATE	SOCIAL SECURITY #	ID #	GROUP #

SIGNATURE: _____ **DATE:** _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE IS REQUIRED.
(PLEASE READ AND SIGN)

I authorize Dr. Roessler to provide diagnostic and treatment services to me. All rendered services, including any changes or updates in existing treatment, will be discussed with me prior to their implementation.

I hereby authorize Dr. Roessler to furnish all of my medical chart information to my insurance carrier or its intermediaries including, but not limited to any protected patient information concerning my treatment. I agree that I will not record, in any way, anything which occurs in the office of Dr. Roessler without prior written consent by Dr. Roessler.

All professional services rendered are charged to the patient. I authorize necessary forms to be completed and submitted for all covered services rendered by the physician to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for surgical procedures in advance and other services when rendered unless other arrangements have been made in advance. Dr. Roessler currently does not participate in Medicaid.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Dr. Roessler or his representatives to release all information necessary to secure payment.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

SIGNATURE: _____

DATE: _____

STAFF: _____

EAR, NOSE & THROAT OF FREEHOLD, LLC

MARK ROESSLER, D.O., F.A.O.C.O.

CONSENT, NOTICE AND ACKNOWLEDGEMENT

I authorize the use and disclosure of my protected health information to include your office contact me in the following manner: (check as many as applicable)

1. Home Telephone: ( ) _____
   - ☐ Leave detailed information
   - ☐ Leave message with office number only

2. Work Telephone: ( ) _____
   - ☐ Leave detailed information
   - ☐ Leave message with office number only

3. Cellular Telephone: ( ) _____
   - ☐ Leave detailed information
   - ☐ Leave message with office number only

I also authorize the following person/persons to whom my protected health information may be disclosed:

_____

_____

_____

_____

ACKNOWLEDGEMENT:
I acknowledge that I have received the attached Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature | Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

_____