

**PATIENT FOLLOW-UP VISIT**  
**The New York Otolaryngology Group, P.C.**  
*The Ear, Nose and Throat Specialists*

**Patient Name:** \_\_\_\_\_ **S.S.#** \_\_\_\_\_

Current Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**Current Primary Care Physician** \_\_\_\_\_

Physician address: \_\_\_\_\_

Physician telephone: \_\_\_\_\_

**Current Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_

Primary Insurance Holder: \_\_\_\_\_

<p><b>Medications</b> <i>Please list all medications you are currently taking</i></p> <p>ÿ None _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p><b>Allergies</b> <i>Please list any allergies to medications or substances</i></p> <p>ÿ None _____</p> <p>_____</p> <p>_____</p>
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**New medical problems since your last visit** *(Please List):* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Reason for the visit** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that I am financially responsible for all fees for services rendered to me including the balance remaining after the possible insurance benefits. I hereby authorize the direct payment of services rendered to me and authorize release of medical information necessary to pay the claim. I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_

*Signature*

*Date*

**Patient** ð

**Guardian** ð

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to New York Otolaryngology Group for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services

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*Signature*

*Date*