BEACH EAR NOSE & THROAT
WILLIAM S. TEACHEY, MD
Comprehensive personal care for your entire family.

(757) 464-9165
Fax (757) 464-4478
www.beachent.com

Welcome to Dr. Teachey's Office

Patient Registration

Last Name _____ First _____ MI____ SS# _____
Address _____ City_____ State _____ Zip _____
Age _____ Date of Birth_____ Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ D ❑ W
Phone _____ Work _____ Cell _____ Occupation _____
e-mail address _____
Employer _____ Employer Address _____
How were you referred to our office? ❑ Yellow pages ❑ White pages ❑ Internet ❑ Friend ❑ Doctor
Name of referring doctor _____
Are you allergic to Penicillin? ❑ Yes ❑ No List any other medication allergies _____
Are you pregnant? ❑ Yes ❑ No List medications you are currently taking _____
Spouse's name _____ Spouse's occupation _____
Spouse's employer _____ Spouse's work/cell _____
Emergency contact: Name _____ Phone _____ Cell_____
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or other Pacific Island ❑ White ❑ Refuse to report/unreported
Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino ❑ Refuse to report/unreported
Language: ❑ English ❑ French German ❑ Japanese ❑ Mandarin ❑ Russian ❑ Spanish
Communication Preference: ❑ E-mail ❑ Patient Portal ❑ Phone ❑ US Mail
Preferred Pharmacy: Name & Address _____
Phone number _____

Responsible Party for Payment (if other than self)

Last Name _____ First _____ MI____ SS# _____
Address _____ City_____ State _____ Zip _____
Age _____ Date of Birth_____ Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ D ❑ W
Phone _____ Work _____ Cell _____ Occupation _____
Employer _____ Employer Address _____

Insurance Information **Be sure to list secondary insurance if you have one**

Primary Insurance:

Name of insurance company _____ ID# _____
Policy holder's name _____ Group # _____
Policy holder's date of birth _____ SS# _____
Address of insurance company _____

Secondary Insurance:

Name of insurance company _____ ID# _____
Policy holder's name _____ Group # _____
Policy holder's date of birth _____ SS# _____
Address of insurance company _____

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WERE YOU INVOLVED IN A RECENT INJURY/ACCIDENT?
❑ Yes ❑ No

Referring and personal physician: I agree to the release of medical information to any of my personal or referring physicians.

Assignment of benefits: I request that payments ofauthorized benefits be made on my behalfto William S. Teachey, M.D. for any services furnished me by William S. Teachey, M.D. I authorize any holder of medical information about me to release to my insurance company and its agents any information to determine these benefits or benefits payable for related services. I understand that I am personally responsible for all charges, regardless of payments made by my insurance company. In the event that my account is referred for collection, I agree to pay the cost of collection, including a 33 1/3% fee.

There will be a $25.00 charge for missed appointments, unless notification is made 24 hours prior to the appointment. (This charge is not covered by Medicare, or other insurance). If your appointment is scheduled for Monday you must call the office by noon the Friday before your appointment.

CONSENTS

Community Exchange: I authorize Beach Ear, Nose, Throat, PC to use any means of electronic transmission to any Health Care Professional, Hospital or Healthcare Facility to exchange my Protected Health Information.

Immunization Registry: I authorize Beach Ear, Nose, Throat, PC to submit electronic data to Immunization Registries or Immunization Information Systems and actual submission in accordance with/to applicable law and practice.

Medication History: I authorize Beach Ear, Nose, Throat, PC to obtain my medication history from Surescripts, an ePrescribe Clearinghouse. The Medication History will include medications prescribed by all healthcare providers.

Patient Referral: I authorize Beach Ear, Nose, Throat, PC to provide an electronic or paper copy of Summary Care Record for each transition of care to another setting ofcare (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) or provider of care or if the practice refers their patient to another provider.

I consent to the Community Exchange, Immunization Registry, Medication History, and Patient Referral as described above.

Date _____ Signature of policy holder or guarantor _____