

**RICHARD HUGHES, MD ENT PC**  
**383 BAY ROAD**  
**QUEENSBURY, NEW YORK 12804**  
**(518)793-4163**

**PATIENT INFORMATION:** Date: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_  
Patient's Name \_\_\_\_\_ Marital Status: S  M  D  W ? Sex: M  F

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ SS# \_\_\_\_\_ Occupation \_\_\_\_\_

**Requesting Physician** \_\_\_\_\_ **Primary Physician** \_\_\_\_\_ **Last MD visit** \_\_\_\_\_

**Health Center?** \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

**Spouse's Name:** \_\_\_\_\_ **Spouse's SS#** \_\_\_\_\_

**In case of an emergency contact:** \_\_\_\_\_

**If patient is a minor, PLEASE FILL IN THE FOLLOWING:**

Legal Guardian Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Guardian SS# \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Message Phone # \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **Employer** \_\_\_\_\_

Patient ID# \_\_\_\_\_ Group# \_\_\_\_\_ Co-pay Amount \_\_\_\_\_

Subscriber SS# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **Employer** \_\_\_\_\_

Patient ID# \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay Amount \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the Provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the Provider in the course of treatment.

List all names of family, friends or others that we may discuss your PHI with (include those who may call on your bill).

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**Signature** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Of patient or parent/guardian if patient is under 21)

**MEDICARE PATIENTS ONLY:** I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to Richard Hughes MD ENT PC for services furnished my by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

**Signature** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Office use only:**

HIPAA Consent Form Signed \_\_\_\_\_ Restrictions to PHI Disclosure Form Signed

Yes\_\_No\_\_(If yes attach copy)

PT INFO

10/05