

New Patient Intake Form

Thank you for your interest in becoming a patient at PearceMD. Please read the following details then complete the form as thoroughly as possible to ensure timely and appropriate scheduling. All forms are reviewed and triaged by our clinical staff because we believe your history and details matter.

- Please Note: as a patient, *it is your responsibility to understand the details of your specific insurance plan.*
- We are able to see new patients regardless of type (or lack of) health insurance.

“In-Network”: Dr. Pearce has thoughtfully chosen to be In-Network with a few insurance carriers:

Traditional Medicare, Mending (Taro) Health, Aetna, Aetna Medicare Advantage, Maine Community Health Option

- For “In-Network” patients, *we will submit* the insurance claim to the carrier to request payment for the contracted portion of the visit/procedure, based on pre-determined rates.
- “In-Network” patients are *financially responsible for any remaining claim costs* not covered and/or as dictated by their insurance coverage details (co-pay, deductible, co-insurance, etc.)

In other words, even if “In-Network”, *you may still receive and be responsible for a bill after your visit*, based on the contracted details of your insurance plan.

“Out-of-Network”: For all other patients including those without insurance (self-pay), we will provide you with the upfront cost before your visit, *and payment is due at the time of service.*

- We are happy to provide you with the necessary paperwork (receipt + superbill summary) for *you to submit the claim* to your insurance carrier after the visit, towards your out-of-network benefits.
- **Please include your insurance information** even if you are “Out-of-Network”. If you do not have health insurance, please write “self-pay” in the box for “Insurance Carrier”.

Name:

Date of Birth:

Phone Number and Email:

Address:

Primary Insurance Carrier & Plan #:

Secondary Insurance Carrier & Plan #:

**Subscribers Name and Date of Birth
(If different than patient):**

How did you hear about our practice?

A referral was sent on my behalf
by _____
(Office specialist, dentist, PCP, etc.)

Another health care provider
suggested I call your office (no
referral sent)

Other: Internet search, word of
mouth, social media, etc.

My preferred method of communication: Phone call Text message Email

Who is your Primary Care Physician? Name _____ Practice _____

Ear Nose Throat **Chief Complaint:** In 1-2 sentences, please describe the reason(s) you are seeking ENT Care?

What would you like addressed at your appointment? Please note, multiple visits may be required!

| | | |
|----------------|-----------------------|------------------|
| Ear Pain | Dizziness/Off Balance | Voice Change |
| Ear Fullness | Vertigo | Post Nasal Drip |
| Ear Drainage | Throat Pain | Nose Bleeds |
| Ear Ringing | Throat Clearing | Nasal Congestion |
| Hearing Loss | Loss of Smell | Nasal Blockage |
| (One Ear Both) | Snoring | Runny Nose |
| Sinus Pain | Sinus Infection | Allergies |

Information on any prior workup or provider visits for your **current ENT concern(s)** will be extremely helpful for us to maximize your visit at PearceMD. If performed, please provide details below:

| | WHO | WHERE | WHEN | DETAILS |
|--------------------------|-----|-------|------|---------|
| ENT Specialist | | | | |
| Urgent Care/ER | | | | |
| Neurology | | | | |
| Allergy/Immunology | | | | |
| Pulmonology/Sleep | | | | |
| Dentist/Oral Surgeon | | | | |
| PT, Speech, Occupational | | | | |
| Hearing Test | | | | |
| CT (cat scan head/sinus) | | | | |
| MRI brain/face/head | | | | |
| Ultrasound/swallow study | | | | |

- Check here if you are being seen at PearceMD as a second (or third, etc) opinion
- Check here if you have not had any prior workup, visits, or imaging for your current ENT concern(s)