Patient Registration Form

Today's Date:______________________________ Date of Birth:____________________________________

First Name:_________________________ MI:___________ Last Name:_______________________________

Home Address: ____
Address City State Zip Code

Billing Address (if different): ____
Address City State Zip Code

Home Phone:____________________ Cell Phone:__________________ Work:______________________

Email:____ Marital Status:_______________

Social Security#:__________________________ Sex:____________ Language:_________________________

Employer Name:_______________________________ Occupation:________________________________

Race: Asian/African American/Caucasian/Hispanic/Native American/Other:________________________

Ethnicity: Hispanic/Latin Not Hispanic/Latin Decline to Answer

Emergency Contact:__________________________________ Relationship:__________________________

Phone Number: _____________________________________

Pharmacy Name:_______________________________ City:____________________ Street:____________

Primary Care Physician:___________________________ Address:_________________________________

Are there any doctors you see besides your Primary Care Physician? If yes, please list:

Physician name: ____________________ Specialty: ________________ Location: ____________________

Physician name: ____________________ Specialty: ________________ Location: ____________________

Physician name: ____________________ Specialty: ________________ Location: ____________________

Insurance Information

This portion *must be filled out* even though we have a copy of your card.

Primary Insurance Company:__________________________________ New Insurance: Yes______ No_______

Subscriber's Name:_______________________________ Date of Birth:______________________________

Relationship to subscriber: Self/Spouse/Child/ Other

Patient ID#:____ Group #:______________________________

Secondary Insurance Company:_______________________________ New Insurance: Yes______ No_______

Subscriber's Name:_______________________________ Date of Birth:______________________________

Relationship to subscriber: Self/Spouse/Child/ Other

Patient ID#:____ Group #:______________________________

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PLEASE NOTE: PATIENTS UNDER THE AGE OF 18 CANNOT BE SEEN BY THE DOCTOR WITHOUT PARENTAL WRITTEN CONSENT.

Patient & Financial Responsibility

By electing to visit Ear Nose & Throat Medical and Surgical Group LLC, it is my responsibility to make sure all insurance and referrals are current at the time of each visit. I will be held financially responsible for any rejected claims due to insufficient referrals or incorrect insurance information.

The Guarantor is responsible for all charges regardless of insurance coverage. All charges are due at the time of service. If the patient has insurance coverage, we will submit claims on behalf of the patient, for benefits for the services rendered. However, the guarantor is responsible for any applicable co-payments, coinsurance, deductibles and non-covered services.

If patient is under age 18, please fill out the information below:

Guarantor for this account: ____

Date of Birth: _________________ Phone number: ___________________

Relationship to patient: _________________________

____ _____________________

Signature of Patient/Guarantor* **Date***

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