

EAR, NOSE & THROAT ASSOCIATES, INC.

Patient Registration Form

Account #: _____

PATIENT INFORMATION

Patient Name: _____ Sex: ___M___F Age: _____

Date of Birth: _____ Soc. Security #: _____

Street Address: _____

City, St., Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Wk Phone: _____

Address: _____

Name of Person Responsible for Bill if Other Than Patient: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name: _____ SS#: _____

Employer: _____ Wk Phone: _____

Mother's Name: _____ SS#: _____

Employer: _____ Wk Phone: _____

INSURANCE INFORMATION

Primary Ins. Co.: _____ Tel. #: _____

Policy #: _____ Group #: _____

Insured's Name: _____ Insured's DOB: _____

Relationship to Patient: _____

Primary Ins. Co.: _____ Tel. #: _____

Policy #: _____ Group #: _____

Insured's Name: _____ Insured's DOB: _____

Relationship to Patient: _____

INSURANCE AUTHORIZATION & ASSIGNMENT

1. I authorize Ear, Nose & Throat Associates, PC, to release to my insurance carriers any information requested concerning my examination or treatment. I understand that I am responsible for any charges NOT covered by my insurance company.
2. I hereby authorize payment directly to Ear, Nose & Throat Associates, PC, for surgical and medical benefits payable for the services performed.
3. I authorize the administration of any anesthetics and analgesics (eardrops and medication) that the Doctor/PA advises.
4. I understand that my insurance company might consider a scope or hearing test to be a procedure; therefore, they will drop it to my deductible.
5. My signature below indicates that I am aware of Ear, Nose & Throat Associates, PC, Privacy Policy and its availability for my review.
6. I agree to inform Ear, Nose and Throat Associates, PC, of any changes to my address, phone numbers or insurance company.

Patient or Guardian Signature

Printed Name

Date