PATIENT REGISTRATION

DATE _____

Patient's Name: _____
Last First M.I.

Home Address: _____
Street City State Zip

Mailing Address: _____
(if different from above)

Billing Address: _____
(if different from above)

Home Phone: _____ Soc. Sec. #: _____

Date of Birth: _____ Sex: (M/F) _____ Status: __S __M __D __W Race: _____

Patient's Employer: _____ Work Phone #: _____

Referred by: _____ Primary Doctor: _____

Parent or Guardian Information (This section must be completed if patient is under 18)

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Date of Birth: _____ Soc. Sec. #: _____

Employer: _____ Work Phone #: _____

Primary Insurance Company Name: _____

Employer Name: _____ Name on Card: _____

Policy #: _____ Group #: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's Soc. Sec #: _____ Subscriber's Date of Birth: _____

Secondary Insurance Company Name: _____

Employer Name: _____ Name on Card: _____

Policy #: _____ Group #: _____

Subscriber's Name: _____ Relationship: _____

Subscriber's Soc. Sec #: _____ Subscriber's Date of Birth: _____

Emergency Contact

Name: _____ Phone #: _____ Relation: _____

Patient's Authorization

I authorize Eastern Shore ENT & Allergy Associates, P.A. to provide medical care and treatment to myself or patient named above if under the age of 18. This authorization is valid for one-year unless revoked by parent(s) or legal guardian(s), or patient is no longer a minor. I also authorize Eastern Shore ENT & Allergy Associates, P.A. to apply for benefits on the patient's behalf for services rendered. I request the insurance make payment directly to Eastern Shore ENT & Allergy Associates, P.A. I certify that the insurance information coverage is correct. I further authorize the release of information, including medical information of any care or treatment, for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing prior to future treatment. My signature below indicates I have read and understand this authorization. Furthermore, I understand and agree to be fully responsible for payment of any service provided, including deductibles, co-payments and non-covered services at the time of services, unless prior arrangements have been made.

_____

Patient Signature (Guardian Signature if Patient is Under the Age of 18) Date