MidWest ENT Centre, PC

New Patient Registration

Today's Date:____/____/____

• Patient Information

Name (last ,first, middle init.): ________________________ Home Phone #: ____________
Address: ________________________ Work Phone #: ____________
City: ________________________ State: ________ Zip:________
Social Security #: ________________ Age:______Date of Birth: ____________
Patient's Employer: ________________________ Occupation: ____________
Employer's Address: ____
City: ________________________ State: ________ Zip:________
Patient's Marital Status: (circle one): Single Married Widowed Divorced Separated
Who is your **primary doctor**? ________________ Whom may we thank for referring you if not your
Who is your **referring doctor**? ________________ Physician? ________________
Spouse's or Parent's Name: ________________ Work Phone #: ____________
Other Emergency Contact: ____________ Home Phone #: ________ Work Phone #: ________

• Responsible Party Information

Name (last ,first, middle init.): ________________________ Home Phone #: ____________
Address: ________________________ Work Phone #: ____________
City: ________________________ State: ________ Zip:________
Social Security #: ________________ Age:______Date of Birth: ____________
Employer: ________________________ Occupation: ____________
Employer's Address: ____
City: ________________________ State: ________ Zip:________

• Insurance Information

Primary

Subscriber's Name: ________________ Social Security #________________ D.O.B.________
Patient's ID #:________________ Group #:________________
Insurance Company: ____
Billing Address: ________________________ Phone Number: ____________

Secondary

Subscriber's Name: ________________ Social Security# ________________ D.O.B________
Patient's ID #:________________ Group #:________________
Insurance Company: ____
Billing Address: ________________________ Phone Number: ____________

Authorization of Release of Information / Consent to Treatment

· I hereby authorize payment directly to ***MidWest ENT Centre, PC*** insurance benefits otherwise payable to me under the terms of my insurance.
· I hereby authorize ***MidWest ENT Centre, PC*** to release information necessary for my insurance company to process my claim.
· I hereby authorize photocopies or facsimiles of this form to be as valid as the original.
· I have completed this form and attest to the accuracy of all the information I have provided.
· I understand that I am responsible for payment in full and/or my insurance copay at the time services are rendered.
· I understand that I am financially responsible for any charges not paid in a timely manner by my insurance.
· I understand that ***if collection should ever be required on your account, collection expenses will be incurred by the responsible party.***

________________________ ____________
Signature of Patient/Parent Date

5/03