

Ear, Nose, & Throat Specialist of St. Cloud

Patient Registration

Office Use Only: Pt#

PATIENT INFORMATION:

Date:

| | | | |
|-----------------|--|---------------------|------|
| Last Name: | Sex: | Birthdate: | Age: |
| First Name: | MI: | Marital Status: | |
| Address: | | Social Security No: | |
| City/State/Zip: | Occupation: <input type="checkbox"/> Fulltime <input type="checkbox"/> Part-time | | |
| Home Phone: | Employer: | | |
| Cell Phone: | Address: | | |
| Email Address: | Work Phone: | | |

PERSON RESPONSIBLE FOR PAYMENT: (For minors, person presenting patient for treatment.)

| | |
|-----------------|---------------------------------|
| Name: | Relationship to Patient: |
| Address: | Social Security No.: Birthdate: |
| City/State/Zip: | Phone: Home Work |
| Cell Phone: | Email Address: |

ALTERNATIVE CONTACT (For minors, please list other parent)

| | |
|-------------------|--------------------------|
| Name: | Relationship to Patient: |
| Address: | Phone: |
| City: State: Zip: | Work Phone: |
| Cell Phone: | Email Address: |

REFERRING INFORMATION: How did you learn about us?

| | |
|--|-----------------|
| Referring Dr: | Family Doctor: |
| Address: | Address: |
| City/State/Zip: | City/State/Zip: |
| Phone: | Phone: |
| Other: <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Physician Referral Service <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other: | |

PRIMARY INSURANCE COMPANY:

SECONDARY INSURANCE COMPANY:

| | |
|----------------------------|---------------------------|
| Insur Co: | Insur Co: |
| Address: | Address: |
| City/State/Zip: | City/State/Zip: |
| Plan Info: | Plan Info: |
| | |
| Policy Holder: | Policy Holder: |
| Sex: Birthdate: | Sex: Birthdate: |
| Policy Holder Soc Sec No: | Policy Holder Soc Sec No: |
| Employer: | Employer: |
| Policy No &/or Group No .: | Policy No &/or Group No.: |
| Patient Relationship: | Patient Relationship: |

AUTHORIZATION & ASSIGNMENT:

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services or any other insurance company and its agents, any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Ear, Nose & Throat Specialist of St. Cloud, for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, and non-covered services. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Patient or Legal Representative Signature: _____ Date: _____