REGISTRATION FORM

PRIMARY CARE PHYSICIAN: _____**PHARMACY:**_____**CITY**_____

PATIENT INFORMATION:

Patient Name (Last) _____ **(First** _____ **(Middle)** _____

Mailing Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Sex: Male** ____ **Female** ____ **SSN:** _____ **Marital Status: M S D W**

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

E-mail:_____ **Primary Language**:_____

Preferred Communication: Phone ☐ **Text** ☐ **E-mail** ☐ **Ethnicity: Hispanic** ☐ **Non-Hispanic** ☐

Race: ___ **Asian/** ___ **African American/** ___**White /** ___ **American Indian Other:**_____

PATIENT EMPLOYER INFORMATION:

Employer Name: _____ **Occupation:** _____**Phone:**_____

Responsible Party Information: (if other than patient) **Relationship to patient:**_____

Responsible Party Name (Last)_____ **(First)**_____ **(Middle)**_____

Mailing Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Sex: Male** ____ **Female** ____ **SSN:** _____

RESPONSIBLE PARTY EMPLOYER INFORMATION:

Employer Name: _____ **Occupation:** _____**Phone:**_____

INSURANCE INFORMATION:

PRIMARY:

Insurance Company Name:_____

Subscriber's name: _____**DOB:**_____ **ID#:**_____ **Grp #:**_____

Relationship to Patient: _____ **Employer Name:** _____

SECONDARY:

Insurance Company Name:_____

Subscriber's name: _____**DOB:**_____ **ID#:**_____ **Grp #:**_____

Relationship to Patient: _____ **Employer Name:** _____

WAS VISIT RELATED TO THE FOLLOWING:

Auto accident: Y N **Workers' Compensation: Y N** **Other Accident: Y N**

EXPLAIN: _____

I give permission to discuss my medical condition, diagnosis and financial account with:

Name: _____**Relationship:**_____**Phone #:**_____

Name: _____**Relationship:**_____**Phone #:**_____

IN CASE OF EMERGENCY:

Emergency contact: Name: _____ **Relationship:** _____ **Phone #:** _____

PLEASE COMPLETE OTHER SIDE

ASSIGNMENT OF BENEFITS

(Please read carefully and sign and date where indicated)

ASSIGNMENT OF BENEFITS: I hereby assign medical and/or surgical benefits, to which I am entitled to: Eastern Connecticut Ear, Nose & Throat. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

❖Please be aware that office procedures and hearing evaluations performed are not included in the standard office visit. A separate charge for these services will be billed to your insurance and may result in patient payment responsibility.

PROTECTED HEALTH INFORMATION (PHI): I GIVE PERMISSION TO EASTERN CONNECTICUT EAR, NOSE & THROAT TO FOLLOW MY INSTRUCTIONS SHOWN BELOW REGARDING MY PHI: The following PHI will remain in effect until revoked or revised by me in writing.

☐ **Confirm appointments and/or leave messages at ____ home ____ cell ____ work via person, answering machine.**

☐ **I acknowledge receipt of Eastern Connecticut Ear, Nose, & Throat's Notice of Privacy:**

☐ **Patient declined Eastern Connecticut Ear, Nose & Throat's Notice of Privacy: _____ Initials.**

***I hereby acknowledge that I have read and understand the above.**
Patient Signature:
_____Date:_____Witness:_____

MEDICARE SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made to me or on my behalf to Eastern Connecticut Ear, Nose & Throat, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the HCFA and its agent any information needed to determine these benefits for related services.

Patient's Signature: _____ Date: _____

HOW DID YOU HEAR ABOUT US?

____Physician ____ Family/Friend ____Internet ____YP.Com