EASTERN CONNECTICUT EAR, NOSE & THROAT, P.C.
PATIENT REGISTRATION FORM

PRIMARY CARE PHYSICIAN: _____ PHARMACY:_____ TOWN:_____

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:_____ How did you hear about us?: _____

Preferred Communication: Phone____ Text____ E-mail____ Primary Language: _____

Ethnicity: Hispanic ___ Non-Hispanic ___

Race: Asian __ African American __ White/Caucasian __ American Indian __ Other:_____

PATIENT EMPLOYER INFORMATION:

Employer Name: _____ Occupation: _____Phone:_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Responsible Party: (Last)_____ (First)_____ (Middle)_____

Relationship to patient: _____

Mailing Address: _____City: _____ State: ___ Zip Code: _____

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

Responsible Party Employer Name: _____ Occupation: _____Phone:_____

INSURANCE INFORMATION:

Patient **PRIMARY** Insurance Company Name:_____

Subscriber name: _____DOB:_____

ID#:_____ Group #:_____Relationship to Patient: _____

Employer Name: _____

Patient **SECONDARY** Insurance Company Name: (if applicable) _____

Subscriber name: _____DOB:_____

ID#:_____ Group #:_____ Relationship to Patient: _____

Employer Name: _____

WAS VISIT RELATED TO: Auto accident: Y N Workers' Compensation: Y N Other Accident: Y N

Explain:_____

PLEASE COMPLETE OTHER SIDE

36 Watson Street, Willimantic, CT 06226 ~ 79 Wawecus Street, Norwich, CT 06360 ~ 121 Broadway, Colchester, CT 06415
860-456-0287 860-886-6610 860-537-1903
Fax: 860-456-3532
www.EasternCTENT.com

EASTERN CONNECTICUT EAR, NOSE & THROAT, P.C.
PATIENT REGISTRATION FORM

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

Name: _____Relationship:_____Phone #:_____

Name: _____Relationship:_____Phone #:_____

IN CASE OF EMERGENCY:

Name: _____Relationship: _____ Phone #: _____

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 copy of 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: _____

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