# EAR, NOSE & THROAT CENTER
# REGISTRATION FORM

(Please Print and complete form)

| Today's date: | **Primary care provider:** |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: ( ) |
|---|---|---|

| City: | State: | Zip Code: | Cell Number: ( ) |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) | Email Address: |
|---|---|---|---|

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

| **Which Pharmacy do you use?** **Name:** **Address:** | **Pharmacy** **Phone Number: ( )** |
|---|---|

| How may we contact you? ❑ Email ❑ Text Message ❑ Voice Mail ❑ Other | Can we leave a message regarding your medical info? Yes ❑ No ❑ |
|---|---|

## INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist.)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative : | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

## ADDITIONAL INFORMATION

Race:
❑ White ❑ Black or African American ❑ Hispanic ❑ Asian
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Decline

Ethnicity:
❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline

Language:
❑ English ❑ Spanish ❑ Other

**ASSIGNMENT AND RELEASE:**

- **I hereby assign my insurance benefits to be paid directly to the Saint Agnes Healthcare.**
- **I understand that I am financially responsible for all non –covered services, co-pays, deductibles, and/or co-insurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not Covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **I authorize Saint Agnes Healthcare to download my current medications for purposes of insurance payment.**
- **I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities.**
- **I hereby consent to treatment by my Saint Agnes Healthcare providers(s). I authorize Saint Agnes Health to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care as needed to process claims and for general healthcare operations, which may include use of an electronic health information exchange.**

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand the protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occurred prior to the date of revocation will not be affected.

By signing this consent, I authorize Saint Agnes Healthcare and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name:_____ Relationship:_____

Method of Communication: _____

Name:_____ Relationship:_____

Method of Communication:_____

This information is correct and up to date to the best of my knowledge.

**SIGNED:**_____ **DATE:**_____