ENT Associates of Central PA

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Patient Registration Form

Please Print

Patient Name :_____ Date of Birth: ____/____/_____ Age_____ Sex: M / F
Preferred Name: _____ Social Security Number: _____-____-_____
Address :_____
(Street) (City/State/Zip)
Primary Phone: _____(Circle one) Cell / Home / Work
Secondary Phone:_____(Circle one) Cell / Home / Work
Email Address: _____
Primary Physician :_____ Referring Physician: _____
Employer (If patient is a minor, parent or guardian's employer): _____

Person Responsible for bill or Parent/Legal Guardian: (Complete ***only*** if different from patient)
Relationship to Patient (please ✓): ( )Spouse, ( )Parent, ( )Legal Guardian (Paperwork must be provided)
Guarantor Name :_____ Date of Birth____/____/_____ Sex: M / F
Social Security Number: _____-____-_____ Email Address: _____
Information same as above: ☐
Address: _____
(Street) (City/State/Zip)
Primary Phone: _____(Circle one) Cell / Home / Work

*****IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US, FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER*****

MEDICARE AND MEDICAID: I certify that the information given by me in applying for payment under the Title VXIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE: I hereby authorize **ENT Associates of Central PA** to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issues payment check(s) directly to the physician(s) rendering the covered services .

I authorize ENT Associates of Central PA to furnish complete information to my insurance carrier or its intermediaries regarding services rendered, indefinitely or until revoked by patient.

Initial : _____

Due to HIPAA enactment regarding patient confidentiality issues, we cannot give or discuss information pertaining to your health with anyone other than yourself. If you would like us to be able to discuss your health with someone else (Example: Spouse, Daughter, Son, etc.) please list their name(s) and relationship(s) below: (This may be revoked at the patient's request with written consent)

_____

_____

Initial : _____

I hereby certify that all of the above information is correct and true and will be reviewed yearly with **ENT Associates of Central PA.** I can revoke or change any of the above information at any time with written consent.

Signature of Patient/ Legal Guardian: _____ **Date:**_____