HILLS E·N·T
INSTITUTE

Patient Registration Form

Date _____

General Information (Please Print)

Patient Name _____ Mr. ___ Mrs. ___ Miss ___ Ms. ___ Sex: M ___ F ___

Date of Birth _____ Age _____ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Primary Address _____ City _____ State ____ Zip _____

Social Security No. _____ Email _____

Home Phone No. _____ Work Phone No. _____ Cell Phone No. _____

Employer _____ Occupation _____

Primary Care Physician _____ Phone No. _____

Address _____

Referring Physician _____ Phone No. _____

Address _____

Pharmacy Name and Phone No. _____

Insurance Information

Person Responsible for Bill _____ Relationship to Patient _____

Address (if different from patient's) _____ Phone No. _____

Insured's Employer _____ Phone No. _____

Primary Insurance Company _____

Subscriber's Name _____Birth Date _____Social Security No. _____

Group No. _____ Policy No. _____ Co-Payment Amount _____

Secondary Insurance Company _____

Subscriber's Name _____Birth Date _____Social Security No. _____

Group No. _____ Policy No. _____ Co-Payment Amount _____

Emergency Contact Information

Name _____ Relationship to Patient _____ Phone No. _____

Patient Authorization and Assignment

I authorize the physician and/or staff of **Hills ENT Institute** to release to my insurance company or representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above-named insurance company to pay directly to **Hills ENT Institute** the amount due for medical or surgical services. I understand that I am financially responsible for services rendered by **Hills ENT Institute** including those deemed non-covered by my insurance company. I understand that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

_____ _____ _____

Printed Patient/Guardian Name | Patient/Guardian Signature | Date Signed