HILLS E·N·T
I N S T I T U T E

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