

HILLS ENT

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 ___

Do you have an Advanced Directive? _____

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, CITY & CROSS ST. _____

Insurance Information

Person Responsible for Bill _____ Relationship to Patient _____

Primary Insurance Company _____

Subscriber's Name _____ Birth Date _____

Secondary Insurance Company _____

Subscriber's Name _____ Birth Date _____

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 abovenamed 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