

**NORTHEAST EAR, NOSE, & THROAT ASSOCIATES, INC.**  
PATIENT REGISTRATION FORM & RELEASE AUTHORIZATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: M or F Social Security # \_\_\_\_\_

\*\*EMAIL ADDRESS: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone #( ) \_\_\_\_\_

**Emergency Contact**

Person: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

If under 18, Parent/

Responsible Party for billing: \_\_\_\_\_ Phone #:( ) \_\_\_\_\_

Address if different

from above: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #( ) \_\_\_\_\_

(We need employer info should we need to contact you in case of an emergency)

How did you hear about us, Circle One:

Referred by Physician Newspaper Ad Yellow Pages Web Site Other: \_\_\_\_\_

\*\*\*\*\*

\*\*\*\*\*This section must be completed to ensure proper billing\*\*\*\*\*

Primary Health Insurance

Secondary Health Insurance

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

\_\_\_\_\_  
Name of primary subscriber to insurance

\_\_\_\_\_  
Name of primary subscriber to insurance

Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Is this visit related to an accident: Y or N if yes, WORK AUTO OTHER: \_\_\_\_\_

Send Accident

Claims/Bills to: \_\_\_\_\_

Where did accident occur: \_\_\_\_\_ Date & Time occurred: \_\_\_\_\_

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to Northeast Ear, Nose, & Throat Assoc., Inc., for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services or other insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I also understand that I am responsible for any coinsurance, deductibles, co-pays, and for any charges incurred due to lack of obtaining proper HMO referrals if required by my insurance plan. I understand nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_