

Registration:

Associates of Otolaryngology, PC

Date	Account ID	Chart ID	Other ID	Internal Use
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Patient Information							
Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home		How did you find us?		
Address 2			Work				
			Cell				
			Email				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact	Phone		Pharmacy			Pharmacy Phone	

Physician	Family Physician	Referring Physician
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Medical Insurance	Name & Address	Policyholder	D.O.B.	Relationship	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address				Home:	Work:	Email:
City	State	Zip Code	Employer Name & Address			Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address				Home:	Work:	Email:
City	State	Zip Code	Employer Name & Address			Occupation

HIPAA Approved Contacts

1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home	Cell
				Work		
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home	Cell
				Work		

Patient's or Authorized Person's Signature

I, the undersigned, give my authorization to treat and assign directly to the Associates Of Otolaryngology, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date
X	

Associates of Otolaryngology, P.C.
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 Denver, CO 80210 Email: info@entmds.com

Please attach all pertinent insurance ID cards for photocopying.