EAR, NOSE AND THROAT ASSOCIATES

Patient Registration

Star indicates required field.

PATIENT INFORMATION

Referred By (Physician's Full Name): _____

★ Name: _____ ★ Birth Date: _____
FIRST M.I. LAST

★ Address: _____
CITY STATE ZIP

★ Primary Phone: _____ message? ☐ YES ☐ NO ★ Email: _____

Secondary Phone: _____ message? ☐ YES ☐ NO ☐ Permission to Communicate via Email

Ethnicity/Race: _____ Preferred Language: _____

Marital Status: _____ Age: _____ Sex: _____ Soc. Sec. Number: _____

Employer: _____

Address: _____
CITY STATE ZIP

Occupation: _____

☐ **GUARANTOR** ☐ **SPOUSE** ☐ **PARENT** *(Check one)*

Name: _____
FIRST M.I. LAST

Address: _____
CITY STATE ZIP

Home Phone: _____ Work Phone: _____

Marital Status: _____ Age: _____ Sex: _____ Soc. Sec. Number: _____

Employer: _____

Address: _____
CITY STATE ZIP

Occupation: _____ Relation to Patient: _____

INSURANCE

Primary Ins. Name: _____ Policy# / ID#: _____ Group#: _____

Subscriber Name: _____ Birth Date: _____ Relation to Patient: _____

Secondary Ins. Name: _____ Policy# / ID#: _____ Group#: _____

Subscriber Name: _____ Birth Date: _____ Relation to Patient: _____

Name: _____ **Date of Birth:** _____

IN CASE OF EMERGENCY

Name of friend or relative not living with you who could reach you in case of emergency.

Name: _____ Phone: _____

AUTHORIZATION TO RELEASE INFORMATION ®ASSIGNMENT OF INSURANCE BENEFITS ® AGREEMENT / CONTRACT

I hereby authorize the release to the insurance company named above any information acquired in the course of my examination of treatment (if patient is a minor, parent or guardian sign).

I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign James E. Caro, Jon K. Thiringer, Andrea Liuzzo or Alyssa A. Stefl any and all insurance benefits due me to the full extent of my financial obligation to said doctor.

I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred. I understand that a rebilling fee/finance charge complying with Oregon State Law will be applied to any overdue balance and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should they be required.

_____

Signed Date