Allergy & ENT Associates

Established Patient Registration

Patient Information

frog13.01.122017

Patient Name: _____ DOB: _____ Age: _____
First Middle Last

Home Address: _____
Number City State Zip Code

Sex: _____Male _____Female

Home Phone #: _____ Work Phone: _____ Cell: _____

E-mail address: _____ Marital Status: __ Married __ Single __ Divorced __Widow

Primary Care Physician/Pediatrician: _____ Phone: _____

Name of Responsible Party (if different from patient)

Name: _____ DOB: _____
First Middle Last

Home Address: _____
City State Zip Code

Preferred Phone # _____

Relationship to Patient: _____ ____**Male** ____**Female**

SS# of responsible party: _____

Insurance Information

Subscriber Name: _____ DOB: _____
First Middle Last

Primary Insurance: _____

Policy #: _____ Group#: _____

Employer: _____

In case of Emergency, Notify:

Name: _____ Relationship: _____ Phone #: _____

Disclosure Information

I authorize Allergy & ENT Associates to disclose or provide any and all protected personal health information to:

Name: _____ Phone # : _____

Relationship to Patient: _____ Date of Birth: _____

Signature: **Date:**

Financial Statement

I understand that I am financially responsible for all services not covered by my insurance company. I also understand that if I do not give a minimum of 48 hours notice for cancellation of allergy skin testing appointments, I will be billed a $52 cancellation fee that is not covered by the insurance plan. Failure to cancel office visit appointments at least 24 hours prior to the appointment will result in a $30 charge. I understand that if my insurance company requires that I have a referral to see a Provider at Allergy and Asthma Associates, it is my responsibility to obtain the referral prior to my appointment. If I am unable to do so, my appointment may be rescheduled or I may be expected to pay for the charges in full at the time of service. I hereby authorize payment to any physician of Allergy & ENT Associates who has treated my dependents or me for medical services rendered.

Allergy & ENT Associates will make every effort to contact your insurance company to verify your benefits. However, verification of insurance benefits is not a guarantee of payment. If the insurance company denies payment or services that are not covered, the Policyholder will become financially responsible for those services.

Signature: **Date:**

Receipt of Privacy Practices

Allergy & ENT Associates reserves the right to modify the privacy practices outlined in their notice. I have had the opportunity to read this notice either on their web site **www.aentassociates.com** or in the office.

Signature: **Date:**