Allergy & ENT Associates
New Patient Registration

Patient Information

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 #: _____

How were you referred to Allergy & ENT Associates?

Physician Referral Friend Internet Insurance Plan Other
(circle one)

Specific name of referral source: _____

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 and 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:**