GREENSBORO EAR, NOSE & THROAT ASSOCIATES, P.A.
PATIENT REGISTRATION

DATE: _____ AGE: _____ DATE OF BIRTH: _____ TO SEE DR: _____

PATIENT: _____ SEX: M _____ F _____
LAST FIRST MI

SOCIAL SECURITY #: _____ MARITAL STATUS: SINGLE_____ MARRIED_____ OTHER_____

HOME ADDRESS: _____ HOME PHONE: _____
STREET CITY STATE ZIP

EMPLOYED: _____ WORK PHONE: _____ CELL PHONE: _____

REFERRING DOCTOR'S NAME AND ADDRESS: _____

PRIMARY INSURANCE CO: _____ ID#: _____

GROUP #: _____ INSURED'S SOCIAL SECURITY #: _____

INSURED'S NAME/DATE OF BIRTH: _____

PATIENT'S RELATION TO THE INSURED: _____

EMPLOYER: _____

SECONDARY INSURANCE CO: _____ ID#: _____

GROUP #: _____ INSURED'S SOCIAL SECURITY #: _____

INSURED'S NAME/DATE OF BIRTH: _____

EMPLOYER: _____

FOR MINOR PATIENTS

MOTHER'S NAME: _____ WORK PHONE: _____ CELL PHONE: _____

MOTHER'S PLACE OF EMPLOYMENT: _____

FATHER'S NAME: _____ WORK PHONE: _____ CELL PHONE: _____

FATHER'S PLACE OF EMPLOYMENT: _____

PLEASE READ AND SIGN BELOW

AUTHORIZATION TO PAY BENEFIT TO PHYSICIAN: I, the undersigned, hereby authorize payment directly to the physician for his services. I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or others involved in processing and collection of this claim.

DATE: _____ RESPONSIBLE PARTY: _____

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage with the above mentioned carriers and assign directly the Physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

RESPONSIBLE PARTY SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____