

**Registration :**

**OTORHINOLARYNGOLOGY, INC.**

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 hear of 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

Medical Insurance	Name & Address	Policyholder	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

**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 OTORHINOLARYNGOLOGY, INC. , 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 use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	<b>OTORHINOLARYNGOLOGY, INC.</b>	
<b>X</b>		P O BOX 1916	Phone: 574-232-4800
		South Bend, IN 46634	Email:

Please attach all pertinent insurance ID cards for photocopying.