PATIENT REGISTRATION

Patient Information:

Today's Date: _____ Account: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City:: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M

Home Phone: _____ Cell: _____ Work: _____

May we leave a message: ☐ *Yes* ☐ *No*

Referring Physician: _____ Primary Physician: _____

Authorized Persons to share information: **Mark what is authorized:**

Name: _____ Relation: _____ ☐ *Billing* ☐ *Medical* ☐ *Scheduling*

Name: _____ Relation: _____ ☐ *Billing* ☐ *Medical* ☐ *Scheduling*

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Guarantor Information: ☐ *Check here if Patient is also Guarantor and skip this section*

Name: _____ Phone No: _____ ☐ H ☐ C ☐ W

Address: _____ Phone No: _____ ☐ H ☐ C ☐ W

City, State, Zip: _____ Relationship: _____

Insurance Information:

Primary Insurance: _____

Policy #: _____ Group#: _____

Insured Name: _____ DOB: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance: _____

Policy #: _____ Group#: _____

Insured Name: _____ DOB: _____

Relationship to Patient: _____ Employer: _____

☐ *Check here if your visit is due to a motor vehicle accident or a Worker's Compensation injury.*

Insurance Assignment and Authorization:

Records Release: I authorize the release of my information, including medical and billing information, to my insurance company and to other providers involved in my care.

Assignment of Benefits: I authorize payment of my medical benefits directly to Minneapolis Otolaryngology, P.A.

Financial Responsibility: I agree to pay any and all charges that exceed or that are not covered by my insurance, including any copay, coinsurance or deductible. I understand that I am financially responsible for all charges, including a collection fee of up to 35% and reasonable legal fees that may be added to my account due to my failure to pay on a timely basis.

I have read the above information and understand that I am responsible for payment for services I receive.
I understand that any authorizations above will remain in effect until otherwise requested in writing.

Patient/Guardian Signature: _____ **Date:** _____

I acknowledge receipt of the Notice of Privacy Practices. Signed _____