ENT Family Clinic ~ Sinus and Snoring MD
Patient Registration Form

Patient Information

Last Name	MI	First Name	
Gender / Social Security Number		Date of Birth	Marital Status
Address	City	State	Zip
Email Address	Cell Phone	Home Phone	
Referred By	Primary Care Provider		
Pharmacy Name	Pharmacy Address		
Emergency Contact Name	Relationship to Patient	Phone	

Insurance Information

Primary Insurance

Insurance Carrier Name	Group Number	ID Number
Insured's Name	Insured's Birthdate	Relationship to Insured

Secondary Insurance (If you do not have secondary or a supplement insurance, please write NONE in the box below)

Insurance Carrier Name	Group Number	ID Number
Insured's Name	Insured's Birthdate	Relationship to Insured

Responsible Party

Billing Name (if other than patient)	Phone	Relationship to Patient

DISCLAIMER

We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowledge of your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains. If your account is more than 90 days past due, it will automatically forward to our collection agencies system. Partial payments will not be accepted unless otherwise negotiated. By signing this statement, I agree to assume responsibility for services not paid by my health insurance, in whole or part. I further authorize the release of any medical information necessary to process my claims

Signature of Patient or Guardian _____ Date _____