PATIENT REGISTRATION FORM

PLEASE PRINT

Were you referred by another Physician? ____Yes ____No If yes, which Physician referred you? _____

PATIENT INFORMATION **ARE YOU PREGNANT ____Yes _____No**

NAME		SEX AGE BIRTHDATE M F _____ ___/___/___	MARITAL STATUS □ Single □ Divorced □ Married □ Separated □ Widowed
ADDRESS		Social Security Number	
CITY STATE ZIP		EMPLOYER	
HOME PHONE		OCCUPATION	
CELL PHONE	EMAIL ADDRESS	EMPLOYER ADDRESS	
WORK PHONE		CITY STATE ZIP	

BILLING: PLEASE COMPLETE IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN PATIENT REFERENCED ABOVE

NAME		RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS		EMPLOYER	
CITY STATE ZIP		OCCUPATION WORKPHONE	
HOME PHONE		EMPLOYER ADDRESS	
CELL PHONE	EMAIL ADDRESS	CITY STATE ZIP	

INSURANCE Please Circle	BLUE SHIELD	AETNA	KEYSTONE	MEDICARE	MEDICAID	WORKMEN'SCOMP	CHAMPUS	OTHER/NONE

WE NEED TO COPY YOUR INSURANCE CARD(S). PLEASE GIVE US ALL PERTINENT INFORMATION REGARDING YOUR INSURANCE COVERAGE. IF YOU HAVE COVERAGE BY MORE THAN ONE CARRIER, SUPPLY INFORMATION OF ALL CARRIERS.

*****IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO US, FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER*****

MEDICARE AND MEDICAID I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made either to me or to **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** on any bills for services furnished me by **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** during the next twelve (12) month period.

ALL OTHER INSURANCE: I hereby authorize **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician(s) and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician(s) rendering the covered services for the next twelve (12) month period.

I authorize **ENT ASSOCIATES OF CENTRAL PENNSYLVANIA** to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

_____ _____

SIGNATURE **DATE**

PATIENT REGISTRATION FORM

PLEASE PRINT

Were you referred by another Physician? ____Yes ____No If yes, which Physician referred you? _____