MONTGOMERY EAR NOSE & THROAT CLINIC, INC.

PATIENT REGISTRATION: (PLEASE PRINT)

NAME:	SEX: AGE: BIRTHDATE:
ADDRESS:	SS#
CITY : STATE: ZIP:	EMPLOYER:
HOME PHONE: ( )	ADDRESS:
WORK PHONE: ( )	CITY: STATE: ZIP:
CELL/PAGER: ( )	PHARMACY NAME:
E-MAIL:	PHARMACY PHONE: ( )

EMERGENCY CONTACT OTHER THAN HOME PHONE **Relationship:**

PHONE: ( ) WORK PHONE: ( )

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐

REFERRED BY:

FAMILY DOCTOR: ADDRESS: PHONE: ( )

WHY ARE YOU SEEING THE DOCTOR TODAY?:

HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN SEEN AT THIS OFFICE BEFORE: yes ☐ Name(s)_____no ☐

RESPONSIBLE PARTY INFORMATION: Complete in full even if the same as above.

NAME:	RELATIONSHIP TO PATIENT	S.S. #
ADDRESS:	OCCUPATION:	
CITY: STATE: ZIP:	EMPLOYER:	
HOME PHONE: ( )	ADDRESS:	
WORK PHONE: ( )	CITY: STATE: ZIP:	

INSURANCE:

Primary Insurance	Secondary Insurance
Address	Address
City State Zip	City State Zip
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Soc. Sec. #	Subscriber Soc. Sec. #
Relationship to Subscriber: ☐ self ☐ spouse ☐ child ☐ other	Relationship to Subscriber: ☐ self ☐ spouse ☐ child ☐ other
Subscriber ID No. Group No.	Subscriber ID No. Group No.
Name on ID Card	Name on ID Card
Subscriber Employer:	Subscriber Employer:

PAYMENT AUTHORIZATION AND AGREEMENT:

I authorize release of any medical information and/or records necessary to process this claim. I understand that my medical insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor. I am ultimately responsible for medical fees incurred during my care or the care of my dependents. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection agency costs and reasonable attorney fees incurred. I hereby authorize Montgomery Ear, Nose and Throat to apply for benefits on my behalf for covered services rendered by him/her or his/her order. I also assign all benefits directly to the doctor. I certify that the information that I have reported above is correct and true. I permit a copy of this authorization to be used in the place of the original. My signature below also authorizes my consent to treat my minor child.

Date _____ Signature _____

OFFICE ONLY FRONT DESK Initials _____ Date _____

NO CHANGES _____ PATIENT Initials _____ Date _____