Welcome to WNY EAR, NOSE & THROAT, P.C.

Patient Registration Form

First Name _____ **Last Name** _____

DOB _____ **Sex** M/F **Marital Status(circle):** Married Single Other Minor **RACE**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Primary phone (____)_____ **Is primary** ___cell or ___home? **Work** (____)_____

2nd phone (___)_____

Primary Doctor (Name, address & phone)_____

Referring Doctor (Name, address & phone)_____

Pharmacy Name (Name, address & phone)_____

INSURANCE INFORMATION

1. Primary Insurance Name _____ Policy# _____ Group# _____

Policy Holder Name _____ DOB:_____

2. Secondary Insurance Name _____ Policy# _____ Group# _____

Policy Holder Name _____DOB:_____

List person(s) & relationship(s) below in which you authorize us to release private medical information about yourself

Name: _____ relationship _____ phone _____

Name: _____ relationship _____ phone _____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS AGREEMENT

I authorize Medicare & other insurance company benefits be made directly to WNY ENT, P.C. on my behalf for any services furnished to me by that party who accepts assignment. I also authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges not covered by insurance**. I am aware that once my claim is submitted to my insurance company, additional charges may accrue for certain procedures (these procedures include, but not limited to audiograms,**

tympanograms, nasal endoscopes, laryngoscopies and biopsies) If payment is denied and we are legally able to bill you, you are agreeing to pay for any unpaid balance not paid by your insurance carrier given to WNY ENT, P.C. for any dates of services in question. If any unpaid balances for services rendered are forwarded for legal action, you will be responsible for any legal &/or attorney fees that arise from such filing. Note: The person listed as the primary contact on the account for a minor will be the person held responsible for charges rendered to a minor. WNY ENT, P.C. does not involve itself with financial responsibility. **My signature below serves as my acknowledgement of WNY ENT's, P.C. HIPAA Privacy Policy & Financial Agreement, Appointment policies, forms/records and collection policies which is posted on their website and hanging in the waiting room.**

May we leave appointment information on: ___ Home/Machine ___w/another person ___Cell/Voice Mail

May we leave Medical information on: ___ Home/Machine ___w/another person ___Cell/Voice Mail

_____ _____

Patient Signature (or parent, if child) Date

THIS FORM MUST BE UPDATED WITH THE PATIENT'S INFORMATION ANNUALLY -5/26/10,R-10/22/10,10/6/11,9/28/12,5/1/13,10/20/14,10/30/15,2/9/16,3/24/16 pvm
5/3/17,jd