Central Colorado ENT, LLC **Patient Registration Form** **DATE: _____**

Name/Address

Last Name:_____ First Name:_____ MI:_____
Address 1:_____ Address 2:_____
City:_____ State:_____ Zip Code:_____

Statistics

Soc. Sec. #:_____-_____-_____ Date of Birth:_____ Sex: Male/Female _____
Home Phone (____)_____-_____ Marital Status (circle one) Married, Single, Divorced, Widow, Other
Employer:_____ Work Phone (____)_____-_____
Spouse/Next of kin:_____ Mobile/cell phone(_____)_____-_____
Responsible Party:_____ email:_____

Referring Physician

Primary Care Doctor:_____Referring MD:_____

Insurance Information

Primary Insurance Company	Identification or Certificate #	Group Number

Name of insured if not self:_____ Relation to Insured:
Insured Address 1_____ Self, Spouse, Child_____
Insured Address 2_____
Insured City_____State_____Zip_____
Insured Date of Birth_____ Insured Soc. Sec. #_____

Second Insurance Company	Identification or Certificate #	Group Number

Name of Insured if not self:_____ Relation to insured:
Insured Address 1_____ Self, Spouse, Child_____
Insured Address 2_____
Insured City_____State_____Zip_____
Insured Date of Birth:_____Insured Soc.Sec.#_____

Other Insurance

Is this Workers Comp? Y/N Is this Motor Vehicle Y/N Is this personal injury? Y/N

Authorizations and Financial Policy

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR.
I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO Central Colorado ENT, LLC FOR SERVICES PROVIDED.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL BALANCES NOT PAID BY MY INSURANCE COMPANY.

Your signature_____

I have received a copy of Central Colorado ENT, LLC "Notice of Privacy Practices". I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Central Colorado ENT, LLC and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patients Signature:_____ Date:_____

Patients Representative Signature:_____ Date:_____