Bluegrass Ear, Nose & Throat Clinic, PSC
General Otolaryngology • Allergy & Sinus Disease • Audiology & Hearing Aids
Clark Clinic B • 225 Hospital Drive, Suite #265 • Winchester • Kentucky • 40391
☎: 859-745-1010 / 866-966-7468 • Fax: 859-745-0080 • www.bluegrassentclinic.com

PATIENT REGISTRATION FORM

Please complete ALL fields, including SOCIAL SECURITY NUMBER, unless not applicable

PATIENT INFORMATION (PLEASE PRINT): Date: _____/_____/20_____

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email address: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status: _____

Race: ❑ White / ❑ African American / ❑ Asian / ❑ Hispanic / ❑ Multiracial

Employment Status: ❑ Employed ❑ Retired ❑ Unemployed / Occupation: _____

Employer: _____ Work Phone: (_____)_____

PARENT/LEGAL RESPONSIBLE PARTY:

Name: _____ DOB: ____/____/____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

OTHER INFORMATION:

Who is your primary care physician? Dr. _____

Referred by which doctor? Dr. _____ Phone: (_____)_____

Preferred ways to contact you regarding appointment reminders (please answer **YES** to at least one):

- Leave a message on your answering machine at home? ❑ Yes / ❑ No
- Leave a message on your cellphone voice mail? ❑ Yes / ❑ No
- Text message? ❑ Yes / ❑ No
- Email? ❑ Yes / ❑ No

Please list the names of anyone you allow our office to discuss your appointment, medical condition, financial information and identify his/her relationship to you.

Name: _____ / Relationship: _____
Name: _____ / Relationship: _____
Name: _____ / Relationship: _____
Name: _____ / Relationship: _____

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PLEASE READ THE FOLLOWING CAREFULLY AND SIGN AND DATE BELOW:

1. **I hereby consent to treatment by Bluegrass Ear, Nose & Throat Clinic, PSC.**

2. **I hereby attest that I have received, read, understood and will abide by the *Office Policies and Procedures* and the *Financial Policy & Responsibility* of the Bluegrass Ear, Nose & Throat Clinic, PSC.**

ASSIGNMENT OF BENEFITS:

3. **I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled. This includes Medicare, private insurance, and other health plans to Bluegrass Ear, Nose & Throat Clinic, PSC. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the release of all of my medical records from other physicians and institutions in order that I may be given the appropriate care.**

AUTHORIZATION TO RELEASE INFORMATION:

4. **I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place to the original signed assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128B of the Social Security Act and 31U.S.C.3801-3812 provides penalties for withholding this information.) We will file all claims as a courtesy to you and your insurance company(s) and all necessary documentation for claim processing.**

×_____ _____/_____/20____
Signature: ❒ Self ❒ Mother ❒ Father ❒ Legal Guardian Date Signed

×_____
Name of Patient or LEGAL Guardian/Responsible Party (PRINT PLEASE)