# Midwest ENT Centre Registration

***ACCT # _____ MD_____***

## PATIENT INFORMATION

**Name: _____ Sex: _____ Marital Status: _____**
**Last First M.I**

**Address: _____**
**Number Street City State Zip**

**Date of Birth:___/___/_____SSN#:_____/____/_____ Email_____**

**Preferred Method of Contact: ☐ Follow My Health Portal ☐ Phone ☐ Mail**

**Please circle Yes or No if a detailed message can be left at these contact numbers-**

**Home No :(____) _____Y N Cell No: (_____) _____Y N Work No: (__)_____Y N**

**Primary Doctor:_____ Referring Doctor: _____**
**First and Last Name First and Last Name**

**Employer: _____Occupation: _____ Retired: __ Student:___**

**Person to notify in case of emergency: _____Phone: _____/_____/_____**

## Primary Insurance Subscriber Information

**Name: _____ DOB: ____/___/_____ Relationship to Patient_____**

**Home Address: _____ SSN: _____/____/_____**

**Home No :(_____) _____ Cell # :(_____) _____**

## Secondary Insurance Subscriber Information

**Name: _____ DOB: ____/___/_____ Relationship to Patient_____**

**Home Address: _____ SSN: _____/____/_____**

**Home No :(_____) _____ Cell # :(_____) _____ ☐ I have a 3rd insurance**

**AUTHORIZATION OF RELEASE OF INFORMATION / CONSENT TO TREATMENT / FINANCIAL RESPONSIBILITY**

* I hereby authorize, Midwest ENT Centre, PC, to release information necessary for my insurance company and/or Medicare to process my claim, and to receive authorized direct payment of insurance benefits otherwise payable to me under the terms of my insurance.
* **I am responsible for my insurance co-payment at the time services are rendered as well as any balance due after insurance has processed my claim(s).** If uninsured, I am responsible for all charges incurred at the time of my visit throughout my care.
* **I am responsible for obtaining referrals as required by my insurance** for services rendered by Midwest ENT Centre, PC.
* I understand that if my account is sent to collections, there is an additional 25% fee that will be incurred.
* I have completed this form and attest to the accuracy of all the information I have provided.

**OVER**

**Release of information: I authorize the *Release of My Information* (medical/financial) about my Midwest ENT visits to the following individuals:**

**Parent _____ Spouse_____ Children /Other_____**
**Name Name Name**

**Authorization to obtain medical records from your physician(s): I hereby authorize the following physicians**

_____
**Physician(s) names that you previously have seen**

_____

**To release my medical records including the diagnosis and records of any treatment or examination, including Test results, Audiograms/ENG, Sleep Study, CT Scan/MRI/Thyroid Ultrasound/FNA, Allergy Test Results, Pathology Reports, Operative Reports, lab results and reports rendered to me at any time to:**

**Midwest ENT Centre**

**4790 Executive Centre Blvd**

**St Peters, MO 63376**

**Phone: 636-441-3100**

**Fax: 636-441-8072**

**X_____ _____ Date of Birth:_____/_____/_____**
**Signature of Patient/ or Guardian Relationship to Patient**

**_____ Date: _____/_____/_____**
**(Please Print) *Patient* and *Guardian's Name***

**X_____**
**Signature of the Guarantor (This is the person who is responsible for paying any balances.)**

**Thank you for choosing Midwest ENT Centre for your ear, nose and throat specialist.**

**COPY OF NOTICE OF PRIVACY PRACTICES AVAILABLE AT FRONT DESK RECEPTION**

11/2014