

# BUCKS E.N.T. ASSOCIATES P.C. REGISTRATION FORM

(Please Print)

Today's date:			Referred by:		
<b>PATIENT INFORMATION</b>					
Patient's Name:			Ethnicity: Spanish/Hispanic Origin <input type="checkbox"/> Not of Spanish/Hispanic Origin <input type="checkbox"/> Patient declined/Unknown <input type="checkbox"/>		Marital status (circle one)
Patient's Cell Number:					Single / Mar / Div / Sep / Wid
Is English your primary language? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your primary language spoken?	Race: White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Declined <input type="checkbox"/>		Birth date: / /	Age:
					Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ( )
P.O. box:		City:		State:	ZIP Code:
Occupation:		Employer:		Employer phone no.: ( )	
Pharmacy Name and Number:					
Family Physician:			Family Physician Phone number:		

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Policy Holder:		Birth date: / /	Address (if different):		Home phone no: (if different) ( )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Policy Holder Social Security number:					
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> Keystone HPE	<input type="checkbox"/> BCBS	<input type="checkbox"/> United Health Care
<input type="checkbox"/> Cigna	<input type="checkbox"/> Horizon	<input type="checkbox"/> Bravo	<input type="checkbox"/> Tri Care	<input type="checkbox"/> Aetna	
<input type="checkbox"/> Other					
ID/Policy Number:		Group:			
Patient's relationship to policy holder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Policy Holders name (if different from above):		Group no.:	Policy no.:
Patient's relationship to policy holder:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

<b>IN CASE OF EMERGENCY</b>			
Emergency Contact Name:		Relationship to patient:	Primary Phone: ( )
			Secondary Phone: ( )

*I hereby give my permission to Bucks ENT Associates to disclose information regarding my treatment to:*

Spouse          Son/Daughter          Other          Physician

Name: \_\_\_\_\_

*I do not give my permission to Bucks ENT Associates to disclose information regarding my treatment to:*

Name: \_\_\_\_\_

*I hereby authorize and direct payment to **BUCKS ENT ASSOCIATES** for the surgical and/or Medical benefits, if any, otherwise payable to me under terms of my insurance. I will be personally responsible for payment if any service is determined to be non-covered, or denied by the third party payor. If invalid insurance is given resulting in non-payment I understand that I will be responsible for all balances incurred.*

*I hereby authorize **BUCKS ENT ASSOCIATES** to release any information acquired in the course of my examination or treatment necessary to process insurance claims. I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to **BUCKS ENT ASSOCIATES**. I hereby authorize photocopies of this form to be as valid as the original.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**MEDICARE ONLY**

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*I request that payment of authorized Medicare Benefits be made to **BUCKS ENT ASSOCIATES** for any services. I authorize any holder of medical information about me to release to \_\_\_\_\_*

*\_\_\_\_\_ any information needed to determine these benefits payable for related services.*

*I understand that if, under Medicare Program Guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment. I understand that I am financially responsible for any account denied or partially paid by the third party payer.*

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_