BUCKS E.N.T. ASSOCIATES P.C.-PATIENT REGISTRATION

PLEASE PRINT DATE:___________________________

FIRST NAME:_____________________________LAST NAME:__________________MIDDLE INITIAL____

STREET ADDRESS:____APT#___________

CITY_________________STATE_______ZIP CODE___________ EMAIL ADDRESS:____________________

HOME PHONE:_____-__________-___________CELL PHONE:_______-__________-_________________

SS #_______________________________DATE OF BIRTH:____________________AGE:______________

SEX:______________MARITAL STATUS: MARRIED____ SINGLE____DIVORCED____WIDOWED_______

OCCUPATION:_________________EMPLOYER:__________________WORK PHONE:________________

**SPOUSE NAME:______________________________________DATE OF BIRTH____________________

SS #_______-______-_________WORK PHONE:_______________CELL PHONE______-______-_______

IF YOU DO NOT HAVE INSURANCE PLEASE CHECK____**IF YOU HAVE INSURANCE, COMPLETE ALL FIELDS:**

****INSURANCE COMPANY NAME:______________________________**

NAME OF POLICY HOLDER:__________________________________ POLICY HOLDER D.O.B.________

RELATIONSHIP TO POLICY HOLDER________________

POLICY ID #_________________________GROUP #____

POLICY HOLDER ADDRESS (IF DIFFERENT FROM ABOVE)_______________________________________

CITY_________________________STATE________________________ZIP CODE___________________

PHONE:_____-______-________CELL #_____-_________-__________SS # _______-______-_________

*****SECONDARY INSURANCE**:___________________NAME OF POLICY HOLDER:__________________

POLICY HOLDER BIRTHDATE:__________RELATIONSHIP TO POLICY HOLDER:______________________

POLICY HOLDER ADDRESS (IF DIFFERENT FROM ABOVE)_______________________________________

POLICY ID #____________________________GROUP #____

*****FAMILY DR NAME**:______________________________PHONE:_______-__________-____________

*****PHARMACY NAME**:______________________________PHONE:_______-__________-___________

**** EMERGENCY CONTACT NAME:____________________**PHONE:_______-__________-____________

RACE/ETHNICITY:___________________________

PRIMARY LANGUAGE:_______________________

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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

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 BUCKS ENT ASSOCIATES 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_____________