North Valley Ear, Nose & Throat Associates

PATIENT REGISTRATION

Patient: First Name: ________________________________ Last Name: _________________________________ MI: _______

Date of Birth: __________________________ SS#: ___________________________________ Sex: Male ☐ Female ☐

Address: ____

City: ____ State: ______________________ Zip: __________________________

Home Phone: ____ Cell Phone: ____

Employer: ____ Work Phone: ____

Marital Status: (circle one) M S W D Spouse's Name: ____

Referring Physician: _________________________________ Primary Care Physician: _______________________________

RESPONSIBLE PARTY / INSURANCE POLICY HOLDER

Name: ____ Relationship to Patient: ____________________________

Address: ____ Date of Birth: ____________________________________

City: ____ Social Security #: ________________________________

Employer: ____ Home Phone: ______________________________________

Position: ____ Work Phone: _______________________________________

PRIMARY INSURANCE COMPANY

Insurance Company: ______________________________

Claims Address: __________________________________

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ID#: _____________________Group #: _______________

Policy Holder's Name: ____________________________

Policy Holders Birth Date: _________________________

Policy Holder's Relationship to Patient:

☐ Self ☐ Parent ☐ Spouse ☐ Other: _____________

SECONDARY INSURANCE COMPANY

Insurance Company: ______________________________

Claims Address: __________________________________

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ID#: _____________________Group #: _______________

Policy Holder's Name: ____________________________

Policy Holders Birth Date: _________________________

Policy Holder's Relationship to Patient:

☐ Self ☐ Parent ☐ Spouse ☐ Other: _____________

PATIENT COMMUNICATION & AUTHORIZATION

Best Method of Contact for Patient/Guardian. Please check ONE:

☐ Home ☐ Cell ☐ Work

Emergency Contact Name: ____________________________________ Relationship to Patient: ____________________

Best Contact Phone: ____ Other Phone: ______________________________

Other than yourself, to whom may we release your protected health or billing information? (Provide first and last name and relationship)

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BENEFIT ASSIGNMENT/ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize the staff of North Valley Ear, Nose & Throat Associates, P.C. ("NVENTA") to provide medical services, either regular or emergency, as may be determined by my physician to be in my best interest (or the best interest of my dependent if I am signing as a parent or guardian).

I authorize payment of medical benefits to NVENTA. I agree that all charges for medical services rendered that are not directly paid by my insurance will also be my responsibility. I hereby authorize NVENTA to release the necessary information regarding me to my health plan in order to complete and process my insurance claims. If my account is sent to collections, I may be responsible for additional collection charges.

I hereby acknowledge that I have been presented with a copy of North Valley Ear, Nose & Throat's NOTICE OF PRIVACY PRACTICES.

____ ___________________________________

Patient/Responsible Party Date