MIDWESTENTCENTRE
Breathe better. Hear better. Live better.

Patient Registration

ACCT _____ *MD*_____

Patient SS#: _____ /_____ / _____ **Name:** _____
Last First M.I

Address: _____
Number Street City State Zip

Gender: M / F **Date of Birth:** _____/_____/_____ **Email:** _____

Home No :(____) _____ **Cell No: (_____)** _____ **Work No: (____)** _____

Please check preference: ☐ **You may leave a detailed message at the above numbers** ☐ **Do NOT leave a detailed message at the above numbers**

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

Employer: _____**Occupation:** _____ **Retired:** ____**Student:**___

EMERGENCY CONTACT:_____***/PH:***_____

I authorize the RELEASE OF INFORMATION (financial information/ medical record) to the following individuals

_____ , _____

Primary Insurance

Insurance Name: _____

Subscriber Name: _____ **DOB:** ____/____/_____ **SSN:** _____/____/_____

Relation to patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐**Other**

If other than "SELF" what is the address of the person who carries the policy? ☐ **Same as above**

Home Address: _____

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

Secondary Insurance

Insurance Name: _____

Subscriber Name: _____ **DOB:** ____/____/____ **SSN:** _____/____/_____

Relation to patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐**Other**

If other than "SELF" what is the address of the person who carries the policy? ☐ **Same as above**

Home Address: _____

Home No :(_____) _____ **Cell # :(_____)** _____ ☐ **Additional Insurance**

OVER ⇨

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

* **I am responsible for obtaining referrals as required by my insurance** for services rendered by Midwest ENT Centre, PC.
* **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 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 understand that if my account is sent to collections, there is an additional 25% fee that will be incurred.
* I authorize Midwest ENT to send me educational and/or marketing information on products and services. I understand I can revoke this authorization in writing at any time.
* I have completed this form and attest to the accuracy of all the information I have provided.

X _____ _____

Patient Signature **Date**

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 Pkwy
St Peters, MO 63376
Phone: 636-441-3100
Fax: 636-441-8072

X_____ **Patient Date of Birth: _____/_____/_____**

Patient Signature

_____

Print Name

COPY OF NOTICE OF PRIVACY PRACTICES AVAILABLE AT FRONT DESK RECEPTION 5/31/2017

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

Patient Name: _____Date:_____ MD _____

Below is a complete list of the medications that I am currently taking.

Please list each medication on a separate line.

MEDICATION NAME:	DOSAGE:	HOW OFTEN DO YOU TAKE IT
Example: Penicillin	*1 tablet*	*2x a day*

LIST ANY ALLERGIES TO MEDICATIONS:

_____