New Patient Registration Form

PATIENT INFORMATION

First name: Middle: Last:

Ethnicity: (check one)	Race:	Language:	Birth date:	Age:	Sex:
☐ Hispanic / Latino ☐ Not Hispanic / Latino			/ /		☐ M ☐ F

Street address: Social Security no.: - - Home phone #: ( ) -

City: State: ZIP Code:

Cell phone #: ( ) -

Employer: Employer phone #: ( ) -

Marital status: (please circle one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referred by (please check one): ☐ Dr. _____ ☐ Insurance Co. ☐ Hospital _____

☐ Family ☐ Friend ☐ Newspaper ☐ Yellow Pages ☐ Search Engines (Google, Bing) ☐ Other _____

What pharmacy do you use?:
(Please provide name & location)

Patient's email address:

Family Doctor (PCP):

Do you have an advance directive? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance:

Subscriber's name:	Subscriber's SSN: - -	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary insurance (if applicable):	Subscriber's name: Subscriber's SSN: - -	Birth date: Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( ) -	Cell phone no.: ( ) -

Pediatric Patients: Name of legal guardian: Relationship to patient:

Patient / Guardian signature: ***Date:*** / /

1-866-306-9565
www.ChesapeakeBayENT.com

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IMPORTANT INFORMATION
PLEASE READ ALL OF THE FOLLOWING AND ACKNOWLEDGE BY SIGNING

ACCEPTANCE OF FINANCIAL RESPONSIBILITY:
I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault.

COLLECTION COSTS:
I hereby agree that should my account balance become delinquent more than 60 days that I will pay for all costs incurred by Chesapeake Bay E.N.T. (CBENT) for the collection of my delinquent account including but not limited to legal fees, court costs and collection agency costs.

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION:
I have read and fully understand CBENT's Notice of Patient Information Practices. I acknowledge receipt of a copy of the policy. I understand that CBENT may use or disclose my personal health information for the purposes of carrying our treatment, obtaining payment and evaluating the quality of services provided. I understand that I have the right to request restrictions of how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that the practice will consider the request for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I understand that other physicians involved in my care, including my referring physician and primary care physician will be kept informed of my treatment.

I hereby consent to the use of my personal health information for the purposes as noted in the Notice of Patient Information Practices. I understand that I have the right to revoke this authorization in writing, at any time by sending such written notification to the Office Administrator at the address listed.

ASSIGNMENT OF BENEFITS:
I hereby authorize payment directly to Chesapeake Bay E.N.T. of the medical and/or surgical benefits of my insurance plan(s).

_____ / / _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

_____
RELATIONSHIP TO PATIENT

1-866-306-9565
www.ChesapeakeBayENT.com

Chesapeake Bay ENT

Current Medications List

Name: _____ **Date of Birth:** _____

Date Last Updated: _____ _____ _____ _____

Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes