Mountain Home ENT & Allergy
PATIENT REGISTRATION FORM

SSN_____ ☐Adult ☐Child Age_____ ☐Male ☐Female

Patient: (First)_____(Middle Int)_____(Last)_____

Date of Birth_____Marital Status_____Race_____Language_____

Mailing Address_____Email_____

City_____State_____Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Employer_____ ☐Retired ☐Unemployed ☐Disabled Other: Student? ☐FT ☐PT

If minor, child lives with: ☐Mother ☐Father ☐Both ☐Other (name)_____

Family Physician_____Referred by_____

RESPONSIBLE PARTY INFORMATION (If patient is a minor, complete below with both parents' information)

Responsible Party_____SSN_____Date of Birth_____

Address_____Email_____

Relationship to Patient_____Employer_____Occupation_____

Home Phone_____Cell Phone_____Work Phone_____

Responsible Party_____SSN_____Date of Birth_____

Address_____Email_____

Relationship to Patient_____Employer_____Occupation_____

Home Phone_____Cell Phone_____Work Phone_____

PRIMARY INSURANCE INFORMATION

(Please give insurance cards and driver's license to front desk)

Plan Name_____Subscriber Name_____

SSN_____Date of Birth_____

Relationship to Patient: ☐Father ☐Mother ☐Spouse ☐Other (name)_____

Secondary Insurance? ☐Y ☐N If Yes, Plan Name_____

Policyholder_____Date of Birth_____

Is This Visit Workers Comp? ☐Y ☐N **Is This Visit Related To Other Accident?** ☐Y ☐N

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment benefits be made to Mountain Home ENT & Allergy unless my account has been paid in full.

Responsible Party Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We are required by law to maintain the privacy and provide individuals with the notice of our legal duties and privacy practices with respect to protected health information (PHI). You may request a complete copy of our Notice of Privacy Practices or access it via our website at www.mhentallergy.com.

Patient (or Representative) Signature:_____Date:_____

Emergency Contact Name_____

Relationship_____Phone Number_____