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 in formation. 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:_____

Patient's Signature: _____Date:_____

Signature of Patient's Representative:_____Date:_____

Relationship to Patient:_____