

**Registration :**

**Ashland ENT, Allergy & Hearing Aid Center**

Date	Account ID	Chart ID	Other ID	Internal Use
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**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:	How did you hear of us?			
Address 2			Work:				
City			Cell:				
State			Zip Code	Employer Name & Address	Occupation		
Emergency Contact	Phone		Pharmacy	Pharmacy Phone			

<b>Physician</b>	<b>Family Physician</b>	<b>Referring Physician</b>
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Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

**Guarantor (Person to be billed, if different than patient)**

1

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:	Work:	Email:	
City			State	Zip Code	Employer Name & Address	Occupation

2.

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:	Work:	Email:	
City			State	Zip Code	Employer Name & Address	Occupation

**Approved Contacts**

1.

Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
					Work:	

2.

Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
					Work:	

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly to Ashland ENT, Allergy & Hearing Aid Center, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of signature on file for all insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the HIPPA privacy practice. I authorize the Practice to use and disclose my health information for purposes of treating me or my dependent, obtaining payment for services rendered to me or my dependent, and conducting healthcare operations.

Signature	Signature Date	<b>Ashland ENT, Allergy &amp; Hearing Aid Center</b>
X		2212 Mifflin Avenue, Suite 130 Ashland, OH 44805 Phone: 419-289-8919 Email:

Please attach all pertinent insurance ID cards for photocopying.