ENT PARTNERS OF TEXAS
ADULT REGISTRATION FORM

Patient Name: ______________________________ Social Security Number: ________-________-__________

Sex: M / F (Circle one) Married/Single/Divorced/Widow Spouse Name:_________________________

Date of Birth: ________/________/_______ Spouse Cell Number:__________________________

Race/Ethnic Group ________________________________ Preferred Language _____________________

Home Address:____
(Street) (City/State/Zip)

Home Phone: (______) _____________-___________ Cell Phone: (______) _____________-____________

Employer Name: _________________________________ Employer Phone Number: (___) ________________

Employer Address: ____
(Street) (City/Street/Zip)

E-mail Address: ____

Preferred Contact Method: (Circle one) Cell Phone/Home Phone/Work Phone/Email/Patient Portal

Preferred Appt. Reminder Method: (Circle one) Cell Phone/Home Phone/Work Phone/Email/Patient Portal

Drivers License # ____________________________ Primary Care Physician: __________________________

Referring Physician: __________________________________Patient Referral:__________________________

Preferred Pharmacy: ________________________ Address: ____

Person responsible for bill (Complete only if different from patient)

Guarantor Name: _____________________________________ Social Security Number: _____ - _____ - _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____

Address: ____ Phone Number: _______________

FIRST INSURANCE INFORMATION

Plan Name: _____________________________________ I.D. Number: ________________________________
Address: _______________________________________ Group Number: ______________________________
Policy Holder: __________________________________ Effective Date: ______________________________
Policy Holder's Social Security Number: _________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

(PLEASE COMPLETE BACK SIDE OF THIS FORM)

SECOND INSURANCE INFORMATION
Plan Name: ____ I.D. Number: ___________________________________
Address: ____ Group Number: _________________________________
Policy Holder: ______________________________________ Effective Date: ________________________________
Policy Holder's Social Security Number: _________ - ________ - ________
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

Who to call for an emergency:
Name: __________________________________ Address:____
Home Phone: (__) _______ - ________ Work Phone: (___) _______-_______ Relationship: ________________

MEDICATION HISTORY CONSENT
I authorize ENT Partners of Texas to obtain my medication history

SIGNATURE:____DATE:________________________________

ASSIGNMENT OF BENEFITS – RELEASE OF INFORMATION FOR BILLING
I authorize treatment of the person named above and agree to pay all fees for such treatment. I also authorize the release of any medical information necessary to process these claims. I hereby authorize ENT Partners of Texas to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account.

SIGNATURE: ____ DATE: ______________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Coordinator or Privacy Officer. My signature acknowledges my receipt of the Notice of Privacy Practices for ENT Partners of Texas.

SIGNATURE: ____ DATE: _____________________________