

EASTERN CONNECTICUT EAR, NOSE & THROAT, P.C.
PATIENT REGISTRATION FORM

PATIENT INFORMATION:

PRIMARY CARE PHYSICIAN: _____ PHARMACY: _____ TOWN: _____

I want to connect my ECENT Health Record to my personal Health App? ____ Yes, generate code ____ NO/decline

Patient Name (Last) _____ (First) _____ (Middle) _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Date of Birth: _____ Sex: Male __ Female __ SSN: _____ Marital Status: M S D W

Home Phone: _____ Work Phone: _____ Cell: _____

E-mail: _____ **How did you hear about us?:** _____

Preferred Communication: Phone ____ Text ____ E-mail ____ Primary Language: _____

Ethnicity: Hispanic ____ Non-Hispanic ____

Race: Asian __ African American __ White/Caucasian __ American Indian __ Other: _____

PATIENT EMPLOYER INFORMATION:

Employer Name: _____ Occupation: _____ Phone: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Responsible Party: (Last) _____ (First) _____ (Middle) _____

Relationship to patient: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Date of Birth: _____ Sex: Male ____ Female ____ SSN: _____

Responsible Party Employer Name: _____ Occupation: _____ Phone: _____

INSURANCE INFORMATION:

Patient **PRIMARY** Insurance Company Name: _____

Subscriber name: _____ DOB: _____

ID#: _____ Group #: _____ Relationship to Patient: _____

Employer Name: _____

Patient **SECONDARY** Insurance Company Name: (if applicable) _____

Subscriber name: _____ DOB: _____

ID#: _____ Group #: _____ Relationship to Patient: _____

Employer Name: _____

WAS VISIT RELATED TO: Auto accident: Y N Workers' Compensation: Y N Other Accident: Y N

Explain: _____

PLEASE COMPLETE OTHER SIDE

36 Watson Street, Willimantic, CT 06226 ~ 79 Wawecus Street, Norwich, CT 06360 ~ 914 Hartford Turnpike, Waterford, CT 06385

860-456-0287 860-886-6610 860-537-1903

Fax: 860-456-3532 Referral Fax: 860-456-8382

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EASTERN CONNECTICUT EAR, NOSE & THROAT, P.C.
PATIENT REGISTRATION FORM

I give permission to discuss my medical condition, diagnosis and financial account with:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ Phone #: _____

ASSIGNMENT OF BENEFITS

(Please read carefully and sign and date where indicated)

ASSIGNMENT OF BENEFITS: I hereby assign medical and/or surgical benefits, to which I am entitled to: Eastern Connecticut Ear, Nose & Throat. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

❖ Please be aware that office procedures and hearing evaluations performed are not included in the standard office visit. A separate charge for these services will be billed to your insurance and may result in patient payment responsibility.

PROTECTED HEALTH INFORMATION (PHI):

I GIVE PERMISSION TO EASTERN CONNECTICUT EAR, NOSE & THROAT TO FOLLOW MY INSTRUCTIONS SHOWN BELOW REGARDING MY PHI: The following PHI will remain in effect until revoked or revised by me in writing.

- Confirm appointments and/or leave messages at ___ home ___ cell ___ work
___ via person ___ answering machine.
- I acknowledge receipt of Eastern Connecticut Ear, Nose, & Throat's Notice of Privacy.
- Patient declined copy of Eastern Connecticut Ear, Nose & Throat's Notice of Privacy. _____ Initials.

***I hereby acknowledge that I have read and understand the above.**

Patient Signature: _____ Date: _____ Witness: _____

MEDICARE SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made to me or on my behalf to Eastern Connecticut Ear, Nose & Throat, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the HCFA and its agent any information needed to determine these benefits for related services.

Patient's Signature: _____ Date: _____