

BEACHES EAR, NOSE AND THROAT, P.A.

Jeffrey E. Brink, M.D.

PATIENT REGISTRATION

PATIENT NAME

LAST _____ FIRST _____ M.I. _____

SSN _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE NUMBER _____

EMPLOYER _____ WORK NUMBER _____

BIRTH DATE _____ SEX _____ MARITAL STATUS _____ RACE _____

E-MAIL ADDRESS _____

REFERRING PHYSICIAN _____

OTHER SOURCE OF REFERRAL: YELLOW PAGES, FRIEND, ETC. _____

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

LAST NAME _____ FIRST _____ M.I. _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PHONE NUMBER _____

EMPLOYER _____ WORK NUMBER _____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME _____ PLAN OR GROUP # _____

INSURANCE CO. ADDRESS _____

PLAN NAME _____ POLICY I.D.# _____

SUBSCRIBER LAST NAME _____ FIRST _____

SUBSCRIBER BIRTH DATE _____ SEX _____ SSN _____

PATIENT /SUBSCRIBER RELATIONSHIP: _____

EFFECTIVE FROM _____ TO _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME _____ PLAN OR GROUP # _____

INSURANCE CO. ADDRESS _____

PLAN NAME _____ POLICY I.D.# _____

SUBSCRIBER LAST NAME _____ FIRST _____

SUBSCRIBER BIRTH DATE _____ SEX _____ SSN _____

PATIENT /SUBSCRIBER RELATIONSHIP: _____

EFFECTIVE FROM _____ TO _____

EMERGENCY CONTACT PHONE # _____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

I hereby authorize Beaches Ear, Nose and Throat, P.A. to bill my insurance company directly for medical services rendered and authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for charges not covered or paid by my insurance company and I agree to pay the costs of collection by an outside agency, including a reasonable attorney's fee, if payment is not made. I authorize the release of pertinent medical information to insurance carriers for claims review or processing. If a referral or authorization is required by my insurance company prior to being seen, I understand it is my responsibility to obtain it from my primary care physician or pay the visit in full at the time the services are rendered. I hereby acknowledge that I have read and understand the office policies as they relate to me.

Patient Name _____

Responsible Party Signature _____

Relationship _____ Date _____