WYOMING HEARING CLINIC

Patient Registration

- Please complete **ALL** blanks. If a question does not apply, please enter "N/A"
- If patient is a child, please complete the parent section in addition to the patient section
- **If your appointment today is for a child you are not the legal parent or guardian of, please see the front desk staff before you complete this form**

MEDICAL NUMBER	PATIENT	PARENT	OTHER PARENT or GUARDIAN
LAST NAME			
FIRST NAME			
MIDDLE NAME			
SOCIAL SECURITY NUMBER			
BIRTHDATE			
GENDER	☐ F ☐ M	☐ F ☐ M	☐ F ☐ M
STREET ADDRESS			
CITY, STATE & ZIP CODE			
REFERRAL DOCTOR (name & phone)			
HOME PHONE			
CELL PHONE			
WORK PHONE			

Patient Information on Race, Ethnicity and Primary Language	RACE (select one)	ETHNICITY (select one)
	___American Indian or Alaska Native ___Black or African American ___Native Hawaiian ___Other Pacific Islander ___White ___More than one race ___Undefined ___Decline to answer	___Hispanic or Latino ___Non-Hispanic or Latino ___Decline to answer PRIMARY LANGUAGE (select one) ___English ___Spanish ___Other (please specify)____________________ ___Decline to answer

EMERGENCY CONTACT (other than already listed above)

NAME: ____ PHONE NUMBER: ______________________________

	Insurance #1	Insurance #2 (please only complete fields that are different from #1)	Insurance #3 (please only complete fields that are different from #1)
Insurance Company			
Full name of insured			
Social Security number of insured			
Birthdate of insured			
ID number of patient			

Please complete both sides of form ➔

Email ______________________________ ☐ Check here to receive educational marketing materials

WORKERS COMPENSATION PATIENTS PLEASE COMPLETE THE FOLLOWING:

Date of injury Case number Employer's name and address

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VICTIMS OF VIOLENT CRIME OR ACCIDENT PLEASE COMPLETE THE FOLLOWING:

Date of injury Case or ID# Accident insurance name and address

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The Health Information Portability and Accountability Act of 1996 (HIPAA) mandates requirements for control of all information you provide us. To guarantee compliance, we require the following signatures from you. We appreciate your understanding and patience.

I ACKNOWLEDGE receipt of the Patient Rights and Responsibilities Policy and the Notice of Privacy Practices of Southeast Wyoming Ear, Nose & Throat Clinic, P.C. and/or Wyoming Hearing Clinic.

Signature: ______________________________ Date: ____________________

ASSIGNMENT OF BENEFITS AND PAYMENT POLICY RECEIPT:

I accept full responsibility for all medical charges incurred on this account, regardless of whether I have insurance coverage or not. I am ultimately responsible for all charges and agree to pay for any non-covered or otherwise denied services. My signature below acknowledges: 1] Receipt of a copy of, my understanding of and my agreement to the Southeast Wyoming Ear, Nose & Throat Clinic, P.C. / Wyoming Hearing Clinic in its entirety. 2] Authorization for my insurance benefits to be paid directly to Southeast Wyoming Ear, Nose & Throat Clinic, P.C. and/or Wyoming Hearing Clinic.

Signature: ______________________________ Date: ____________________

AUTHORIZATION TO RELEASE INFORMATION:

We may release information in your records to the person[s] named below. *Do not list other doctors.*
If you do not want us to release your information to any other person, please put "N/A" in the Name Space.

I authorize Southeast Wyoming Ear, Nose & Throat, P.C. and/or Wyoming Hearing Clinic to release patient private medical and administrative information to the individual[s] listed below. I understand this authorization is valid unless I rescind it in writing.

Name: ______________________________ DOB: ____________________

Name: ______________________________ DOB: ____________________

Name: ______________________________ DOB: ____________________

Name: ______________________________ DOB: ____________________

Signature: ______________________________ Date: ____________________