IOWA ENT CENTER PLLC

REGISTRATION FORM

Acct#_____

Staff Initials _____

Provider_____

Name: _____
First Middle Last

Date of Birth: _____/_____/_____ **Sex:** ☐Male /☐Female **Marital Status:** ☐Single /☐Married /☐Widow /☐Divorced

Social Security#: _____/_____/_____ **Email address:** _____

Address: _____
Street or PO Box City State ZIP

Home Phone: (____) _____**Cell Phone:** (____) _____ **Work Phone:** (____)_____

Patient Employer: _____**Language:** _____ **Ethnic:** _____ **Race:** _____

Patient's Spouse: _____ **Spouse Employer:** _____ **Phone:** (____)_____

Referring Doctor: _____ **Family Doctor:** _____

Emergency Contact: _____Relationship:_____ Phone: (____)_____

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Primary Insurance: _____ Name of Policy Holder: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____Employer: _____

Insurance ID#: _____ Group#: _____ Copayment: _____

Secondary Insurance: _____ Name of Policy Holder: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____ Employer: _____

Insurance ID#: _____ Group#: _____ Copayment: _____

********** ***Please complete the following if the patient is a minor or full time student*** **********

Parent Name: _____Date of Birth: _____/_____/_____ Phone: (_____)_____

Address if different than patients: _____

Employer: _____ Employer Phone: (_____)_____

Parent Name: _____Date of Birth: _____/_____/_____ Phone: (_____)_____

Address if different than patients: _____

Employer: _____ Employer Phone: (_____)_____

How did you hear about our clinic? (Mark one box) ☐ Doctor ☐ Insurance Plan ☐ Family/Friend ☐ Yellow Pages/Internet

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Iowa ENT Center or its billing company to release any information required to process my claims.

Patient/Guardian Signature: _____ **Date:** _____