

# Liberty Circle ENT

Proctorville, Ohio

REGISTRATION FORM 1

DATE \_\_\_\_\_

PATIENT'S LAST NAME			FIRST NAME			MIDDLE INITIAL		
SOCIAL SECURITY NUMBER		BIRTH DATE	AGE	PATIENT'S CELLULAR NO. ( )		HOME TELEPHONE NO. ( )		
MAILING ADDRESS			CITY	STATE	ZIP CODE		REFERRING PHYSICIAN	
DRIVER'S LICENSE NO.		SEX M    F	MARITAL STATUS Single   Married   Divorce   Widowed			FAMILY PHYSICIAN		
EMPLOYED BY		EMPLOYER'S ADDRESS			OCCUPATION		BUS. PHONE	
SPOUSE'S NAME		EMPLOYED BY		EMPLOYER'S ADDRESS		BUS. PHONE		
NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU				RELATIONSHIP TO PATIENT		PHONE NO.		
NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU				RELATIONSHIP TO PATIENT		PHONE NO.		

**RESPONSIBLE PARTY: PLEASE COMPLETE THE SECTION BELOW IF THE PATIENT IS UNDER 18 YEARS OF AGE.**

NAME OF RESPONSIBLE PARTY		STREET ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE NUMBER ( )	RELATIONSHIP TO PATIENT				DRIVER'S LICENSE NO.		
EMPLOYER		EMPLOYER'S ADDRESS			CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER		BIRTH DATE			BUSINESS PHONE		

INSURANCE CARRIER(S) INFORMATION					
PRIMARY	LAST NAME	FIRST NAME	M. INITIAL	D.O.B.	SOCIAL SECURITY #
SECONDARY	LAST NAME	FIRST NAME	M. INITIAL	D.O.B.	SOCIAL SECURITY #

**CHIEF COMPLAINT FOR BEING SEEN:** \_\_\_\_\_

IS HEARING LOSS, NOISE IN THE EARS, OR DIZZINESS YOUR PRIMARY PROBLEM?

YES                      NO

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

OFFICE POLICY: OUR OFFICE WILL FILE YOUR INSURANCE. ALL CO-PAYS AND DEDUCTIBLES ARE DUE ON THE DAY OF SERVICE. PRIVATE PAY PATIENTS WILL NEED TO MAKE PAYMENT ARRANGEMENT BEFORE BEING SEEN BY THE DOCTOR.

INSURANCE AUTHORIZATION: I HEREBY AUTHORIZE LIBERTY CIRCLE ENT TO RELEASE TO MY INSURANCE ANY AND ALL INFORMATION CONTAINED IN MY RECORDS. I ALSO AUTHORIZE ASSIGNMENT AND PAYMENT DIRECTLY TO LIBERTY CIRCLE ENT.