

**North Valley Ear, Nose & Throat
PATIENT REGISTRATION**

Patient: First Name _____ Last Name _____ MI _____
Date of Birth _____ SS# _____ Sex: Male Female
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____
Marital Status: (circle one) M S W D Spouse's Name: _____
Physician's Name: _____ PCP: _____

PARENT / RESPONSIBLE PARTY (if not patient)

NAME _____	RELATIONSHIP TO PATIENT _____
ADDRESS _____	DATE OF BIRTH _____
CITY _____ STATE _____ ZIP _____	SOCIAL SECURITY NO. _____
EMPLOYER _____	HOME PHONE _____
POSITION _____	WORK PHONE _____

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

NAME _____	NAME _____
ADDRESS _____	ADDRESS _____
_____	_____
ID # _____ GROUP # _____	ID # _____ GROUP # _____
POLICY HOLDER'S NAME _____	POLICY HOLDER'S NAME _____
POLICY HOLDER'S BIRTHDATE _____	POLICY HOLDER'S BIRTHDATE _____
POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____	POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____

PATIENT COMMUNICATION & AUTHORIZATION

EMERGENCY CONTACT NAME _____	RELATIONSHIP TO PATIENT _____
HOME PHONE _____	WORK PHONE _____

THE FOLLOWING PERTAINS TO THE ABOVE NAMED PATIENT. PLEASE CHECK **ALL THAT APPLY**: O.K. TO CALL HOME AND LEAVE MESSAGES
 DO NOT CALL HOME PHONE O.K. TO CALL WORK NUMBER CALL WORK NUMBER ONLY DO NOT CALL WORK NUMBER
OTHER THAN YOURSELF, TO WHOM MAY WE RELEASE YOUR PROTECTED HEALTH OR BILLING INFO.? (Provide first and last name and relationship)

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize the staff of North Valley Ear, Nose & Throat Associates, P.C. (NVENTA) to provide such medical services, either regular or emergency, as may be determined by my physician to be in my best interest (or the best interests of my dependent if I am signing as a parent or guardian). I authorize payment of medical benefits to NVENTA. I agree that all charges for medical services rendered that are not directly paid by my insurance will be my responsibility. In the event it becomes necessary for NVENTA to forward my account balance to an outside collection agency, I understand I will also be responsible for paying a 40% collection fee, based on the balance of the account. I hereby authorize NVENTA to release the necessary information regarding me to my health plan in order to complete and process my insurance claims.

I hereby acknowledge that I have been presented with a copy of North Valley Ear, Nose & Throat's NOTICE OF PRIVACY PRACTICES.