Patient Registration

Patient Information:

Name: _____ Today's Date: _____/_____/_____

Sex: ____ Age: _____Birthdate: _____/_____/_____Social Security #: _____-_____-_____ Marital Status: S M D W

Race: _____ Ethnicity: _____ Language: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____Work Phone #: _____ Mobile Phone #: _____

Okay to leave messages at (check all that apply): _____ Home Phone _____ Cell Phone _____Work Phone

Email address: _____ Okay to communicate and/or send PHI: _____ (**EMAILS ARE NOT ENCRYPTED and could be read or otherwise accessed by a third party while in transit)**

For minors:

Guardian/Responsible Party: _____ Relationship to Patient: _____

Birthdate: _____/_____/_____ Social Sec #: _____ Tel#: _____

Address (if different from patient's): _____

Primary Insurance:

Insurance Co. Name _____ ID# _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Address: _____

Employer: _____ Insured's Birth Date _____/_____/_____

Secondary Insurance:

Insurance Co. Name _____ ID# _____ Group # _____

Insured's Name _____ Relationship to Patient _____

Insured's Address: _____

Employer: _____ Insured's Birth Date _____/_____/_____

- ***Tertiary Insurance:*** **See Attached information**

I authorize my insurance company to issue the medical benefits of my plan directly to Aurora ENT, Dr. Totten, for services rendered to me. I understand and agree that if insurance does not cover services, I am ultimately responsible for all charges. I also authorize the release of all information to my insurance company regarding my treatment, the diagnosis, or my condition that will aid in payment.

Patient/Responsible Party Signature _____ **Print Name** _____

Date _____/_____/_____ Aurora ENT, LLC Dr. Mary Totten 907-277-6673/Fax: 907-277-6695

Aurora ENT, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

AURORA ENT

Consent for Involvement in Care

In order to comply with specific HIPAA rules and regulations, we ask that our patients complete and sign this privacy and security of health information. **Unless this form is completed, we cannot talk to anyone but you.**

I,_____, hereby authorize Aurora ENT and staff to speak to the person(s) listed below (patient name)
regarding the information selected for each individual, and leave messages regarding my appointments at the listed phone number(s).

Name	Relationship	Phone Number	Billing ONLY	Medications ONLY	ALL PHI
1			☐	☐	☐
2			☐	☐	☐
3			☐	☐	☐
4			☐	☐	☐
5			☐	☐	☐
6			☐	☐	☐
7			☐	☐	☐
8			☐	☐	☐

Do you consent to Aurora ENT obtaining your prescription history from your pharmacy: ***YES*** or ***NO***

Email address: _____ ***YES*** or ***NO***

(If email is declined, you will not receive EMR notifications)

I understand and assume the responsibility of informing Aurora ENT whenever the above information changes. I understand this release **excludes** insurance companies, attorneys, and other health care providers. My signature acknowledges that I have reviewed my demographic information on file with this office.

_____ _____ Patient/Guardian

Signature Date

Aurora ENT, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.