

## 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 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Email address: \_\_\_\_\_ Okay to send PHI (Personal health information): **YES or NO**  
(EMAILS ARE NOT ENCRYPTED and could be read or otherwise accessed by a third party while in transit)

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