ACENT
ALASKA CENTER FOR EAR NOSE AND THROAT

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PATIENT REGISTRATION

In order to serve you properly we require the following information. Please COMPLETE ALL Sections. ***(PLEASE PRINT)***

Patient Information:

First Name: _____ M.I. _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home#: _____ Cell#: _____ Work#: _____

Birth Date: _____ Gender: ☐ Male ☐ Female Preferred Language: _____

Marital Status: _____ Email: _____

SSN#: _____ Would you like us to email you our latest newsletter? Y ☐ N ☐

Employer: _____ Preferred Contact *(circle one):* Home Phone | Cell Phone | Work Phone

Occupation: _____ Referring Physician: 1. _____ 2. _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American

☐ Hawaiian/Pacific Islander ☐ Caucasian ☐ Other Race ☐ Declined

Please check below all boxes that apply to you:

Employed ☐ Minor ☐ Retired ☐ Disabled ☐ Full-Time Student ☐ Unemployed ☐ Other ☐

Parent/Legal Guardian Information: (If patient is a minor or disabled)

Full Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____

Birth Date: _____ Phone: _____

SSN#: _____ Employer: _____ Work Phone: _____

Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: _____

Subscriber's name: _____ Birth Date: _____

SSN#: _____ Subscriber's Relationship: _____

Employer name: _____ Type of Plan *(circle one)*: Actively Employed | Retiree Plan | COBRA

Secondary Insurance Information: (Please provide your insurance card to our front office staff)

Insurance Co name: _____

Subscriber's name: _____ Birth Date: _____

SSN#: _____ Subscriber's Relationship: _____

Employer name: _____ Type of Plan *(circle one)*: Actively Employed | Retiree Plan | COBRA

Emergency Contacts:

Name: _____ Name: _____

Contact#: _____ Contact#: _____

Relationship to Patient: _____ Relationship to Patient: _____

Would you like your emergency contact person to be able to discuss your medical information and/or billing account?
Yes ( ) No ( )

Authorization and Assignment

I assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to ACENT. This assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. **I understand that I am financially responsible for all charges incurred from medical treatment at ACENT, whether or not the services are paid by my insurance.** If, for any reason, it becomes necessary for ACENT to engage an attorney or collections agency to secure payment

Signature: _____ Date: _____