ONSLOW
EAR NOSE & THROAT

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ADULT REGISTRATION FORM (PLEASE PRINT)

Today's date:	PCP:

PATIENT INFORMATION

Patient's full name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address/PO Box:	Social Security no.:	Driver's License:

Home phone no. ( )	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Physician Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	Other:

Other family members seen here:

INSURANCE INFORMATION

Primary Insurance Carrier Name	Policy ID	Group#

Insured's Name:	Soc. Sec. No (if not listed above):	Date of Birth (if not listed above)

Patient's relationship to subscriber:	❑Self	❑ Spouse	❑Child	Other:

Secondary Insurance Carrier Name	Policy ID	Group#

Insured's Name:	Soc. Sec. No (if not listed above):	Date of Birth (if not listed above)

Patient's relationship to subscriber:	❑Self	❑ Spouse	❑Child	Other

PATIENTS RIGHTS AND RESPONSIBILITIES, NOTICE OF PRIVACY PRACTICES, PHOTO IDENTIFICATION

I have been provided with the following documents from Onslow Primary Care: Your Rights and Responsibilities as a Patient, Notice of Privacy Practices. These documents are also available online at the practice's website (www.onlsowprimarycare.org).

I authorize the release of information concerning my healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to Onslow Ambulatory Services, Inc. (For Medicare beneficiaries, this serves as a lifetime authorization assigning payment of Medicare benefits to ECOC)

To protect myself as a patient, and this practice, I agree to have my picture taken at my initial visit, which will be kept in my chart. I may decline having my picture taken, but must state so at that time. I understand that I am personally responsible for all charges not covered by my insurance.

Patient Signature_____ Date _____