The ENT Specialists

Patient Registration Form

57 East Ogden Avenue, Clarendon Hills IL 60514

Who May We Thank for Referring You: _____ **Primary MD:** _____

Name: Date of Birth:

Address: City: State: Zip:

Home Phone: Work Phone:

Email: Sex: M F Marital Status:

Pharmacy Name and Location:

Policy Holder Information

Name: Date of Birth:

Address: City: State: Zip:

Home Phone:

Patient's Relationship to Policy Holder: Spouse Child Other:

Please present Insurance Cards along with Picture ID for copying

Copay Amount

Primary Insurance Name: Phone Number:

Identification Number: Group Number:

Is this claim due to workman's comp? Y N Contact Phone Number:

Claim Number:

Emergency Contact: Phone Number: Relation:

*Consent for examination and treatment: I, hearby authorize the health care provider at The ENT Specialists to examine, administer treatment; medical or surgical, deemed necessary or advisable.

Signature: Date:

*Financial Agreement: I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature: Date: