

Patient Registration:

Account # _____

ENT PHYSICIANS & SURGEONS PA.
130 Tarrytown Rd, Manchester, NH 03103
166 Kinsley Street, Suite 302, Nashua, NH 03060
240 S. Main Street, Suite G, Wolfeboro, NH 03894
. 101 Boulder Point Rd, Suite 2, Plymouth, NH 03264

Last name: _____ First name: _____ Middle Initial: _____

Home Phone: _____ Cell Phone: _____ Marital Status: S M D W Soc.Sec.# _____

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

Street Address: _____ City: _____ State: _____ Zip: _____

Other Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SEX: M / F Student Y / N Employed Y / N Retired Y / N

Employer: _____ Address: _____ Telephone: _____

Primary Care Physician: _____ Address: _____ Telephone: _____

Referring MD (if different from above): _____ Address: _____ Telephone: _____

Patient's Relationship to insured: ___ Self ___ Spouse ___ Child ___ Other

Spouse's Name: _____ Date of birth: _____ SSN: _____ is spouse a patient? Y / N

Nearest Relative / friend **not** in the same Household : _____ Telephone: _____

Complete if patient is a minor or under parents insurance

Mothers Name: _____ SSN: _____ Date of birth: _____ Age: _____

Employer: _____ Address: _____ Telephone: _____

Fathers Name: _____ SSN: _____ Date of birth: _____ Age: _____

Employer: _____ Address: _____ Telephone: _____

Insurance information

Primary Insurance: _____ Subscriber: _____ Cert# _____ Group # _____

Claims Address/city/state/zip: _____ Telephone: _____

Secondary Insurance: _____ Subscriber: _____ Cert #: _____ Group #: _____

Claims Address/city/state/zip: _____ Telephone: _____

I HAVE BEEN OFFERED A COPY OF THE PRIVACY PRACTICE POLICY

I UNDERSTAND AND AGREE THAT IF I FAIL TO MAKE ANY OF THE PAYMENTS FOR WHICH I AM RESPONSIBLE IN A TIMELY MANNER, I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTING MONIES OWED, INCLUDING COURT COSTS AND ATTORNEY FEES.

**I UNDERSTAND THAT MY SIGNATURE AUTHORIZES PAYMENT BY THE INSURANCE TO THE PROVIDER
I AUTHORIZE THE RELEASE OF ALL MEDCAL INFORMATION NECESSARY TO PAY THE CLAIMS AND/OR FOR CONTINUITY OF PATIENT CARE.**

**SIGNATURE: _____ DATE: _____
PATIENT OR LEGAL GUARDIAN OR POA**