**REGISTRATION FORM**

Patient Name: _____ _____ _____ ☐ Male ☐ Female
**Full Name** **Date of Birth** **Age** **Sex**

Patient Address: _____
**Street** **City** **State** **Zip Code**

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

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**Ethnicity**: ☐ **Caucasian** ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **All Others** ☐ **Declined to Specify**

**Race**: ☐ **White** ☐ **African American** ☐ **Asian** ☐ **More Than One Race** ☐ **Native American**

☐ **Other Polynesians** ☐ **Decline to Specify**

**Language**: ☐ **English** ☐ **Other:** _____ ☐ **Declined to Specify**

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E-Mail Address: _____

Home Phone: _____ Cell Phone: _____

Patient's Employer: _____ Spouse Name: _____

Patient's Work Phone: _____ Spouse Employer: _____

Patient Social Security#: _____ Spouse Work Phone Number: _____

***Due to the new Kasper law implemented by Kentucky we must have Social Security numbers on all patients including children.***

**Referring Doctor:** _____ **Primary Care Physician:** _____

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**IF PATIENT IS A CHILD: COMPLETE THIS SECTION**

Father's Name: _____ Mother's Name: _____

Father's Date of Birth: _____ Mother's Date of Birth: _____

Father's Address: _____ Mother's Address: _____

_____ _____
CITY ZIP CITY ZIP

Father's Home Phone: _____ Mother's Home Phone: _____

Father's Employment: _____ Mother's Employment: _____

Father's Work Phone: _____ Mother's Work Phone: _____

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**GUARDIANS: COMPLETE THIS SECTION**

Guardian's Name: _____ Guardian's Phone: _____

Guardian's Date of Birth: _____ Guardian's Cell Phone: _____

Guardian's Address: _____ _____
STREET CITY ZIP

Guardian's Employment: _____ Guardian's Work Phone: _____

Patient Name:_____

**Local Pharmacy: _____ Address: _____ Phone_____**

_____
**CITY ZIP**

**Mail-In Pharmacy: _____ Address: _____ Phone: _____**

_____
**CITY ZIP**

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**INSURANCE INFORMATION:**

Primary Insurance: _____ Secondary Insurance: _____

Name of Policyholder: _____ Name of Policyholder: _____

Policyholder's Date of Birth: _____ Policyholder's Date of Birth: _____

Policyholder's Employer: _____ Policyholder's Employer: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policyholder's ID#: _____ Policyholder's ID#: _____

Group#: _____ Group#: _____

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## Other immediate family (parents, brothers, sisters) members seen by our practice: Please Print

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

NAME: _____ DOB: _____

**Harold W Blevins MD, PSC** dba **ENT ASSOCIATES** participates with most commercial insurance companies, traditional Medicaid and Medicare plans. Prior to your office visit, please check with your insurance company to make sure that **Harold W Blevins MD, PSC** dba **ENT ASSOCIATES** is a participating provider within your insurance network. Some plans require a written referral from your primary care physician. It is the patient's responsibility to obtain any referral prior to your visit. If your referral is not present at the time of service your appointment will need to be rescheduled.

**Co-pays** are due on day of service. We will file your insurance for you. You are responsible for any deductibles or co-insurance. After your insurance company pays its portion, our billing department will work with you to set up a payment plan if necessary. If the account balance is not paid within the allowed time, your account will be turned over to GLA Collection Services.

I also request payment of government benefits either to myself or to the party who accepts assignment, and payment of medical benefits to **Harold W Blevins MD, PSC** dba **ENT ASSOCIATES** by my insurance company for services provided.

I agree that I am responsible for any charges, which are not authorized by my insurance company or government agency.

Consent to Telephone calls: If at any time I provide a telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collections agencies.

Consent to email usage: If at any time I provide my email address at which I may contacted, unless I notify the office to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at that email address from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

**You have my permission to leave my financial/billing information on:**

**Choose All that Apply:** ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone** ☐ **Mail** ☐ **Fax** ☐ **Email**

_____ _____

**Patient/Guardian (Please Print)** **Signature Patient/Guardian**

_____

**Date**