PLATTSBURGH ENT
PATIENT REGISTRATION FORM

Prefix/Suffix:	**First:**	**MI.**	**Last:**
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**SS#:**	**Birth Date:**
Work Phone:	**Race (optional):**	**Sex (circle one):** **M F**	**Age:**
Marital Status:	**Primary Care Doctor:**	**Email:**	
Emergency Contact:	**Phone:**	**Relationship:**	

Primary Insurance:	**Secondary Insurance:**
Policy #:	**Policy #:**

HIPAA/PHI
Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Plattsburgh ENT's. **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Further, I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I am also signing that I have received Plattsburgh ENT's financial agreement.

Signed: _____ Date: _____

If not signed by patient, please indicate your relationship to the patient (e.g., spouse, sibling)

Relationship to patient: _____