Southwestern Colorado Ear, Nose & Throat Associates

Gregory M. Schackel, MD

Patient Registration

PATIENT

Name_____ M/F Age_____ Date of Birth _____
Mailing Address_____ Home Phone # _____
Physical Address_____ Cell Phone # _____
City_____ State____ Zip_____ Social Security # _____
Name of Employer_____ Work #_____
Spouse's Name_____ Spouse's Work # _____
Spouse's Employer_____ Email _____

GENERAL INFORMATION

Referred to our office by _____
Your personal Family Physician_____
Next of Kin, Name and Phone # _____

INSURANCE INFORMATION

Please give your insurance cards to the receptionist to copy. Thank you.
Primary Insurance Company_____
Secondary Insurance Company _____
Card Holder's Name _____Card Holder's Date of Birth_____

FILL OUT IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name _____ Work #_____
Mother's Name _____ Work#_____
Responsible Party _____Work#_____
Social Security Number of Responsible Party_____

- I acknowledge that I have been given access to either review or receive Southwestern Colorado Ear, Nose and Throat's Privacy Notice. I authorize Southwestern Colorado Ear, Nose and Throat to release my Private Health Information to:

__Spouse __Parent __Child __Other_____

* I would like a copy of the Privacy Act emailed to me ☐ Yes ☐ No

- I understand that I am responsible for all charges not paid by my insurance company. I authorize the release of medical information to my insurance company. If insurance company claims are filed through this office (for surgeries, office visits, etc), I authorize medical benefits for those services to be paid to this office.

- If my insurance company (including Medicaid) requires a prior authorized referral, it is my responsibility to obtain this referral from my primary care physician prior to visiting Southwestern Colorado Ear, Nose and Throat Assoc. In the event that I choose to be seen without prior authorization, I understand that I will be responsible for services rendered.

- I further understand that payment; co-payments and deductible payments for all office services are due at time of visit. If payment or co-payment is not made at the time of service, an additional fee may be added to my bill.

Cash, Checks, Mastercard and Visa Cards accepted

Signature_____**Date**_____

If signature is other than patient's, please mark your relationship to the patient:

__Spouse __Parent __Child __Other_____

_____Updated_____Updated_____Updated_____Updated_____Updated