CHICAGO

NASAL & SINUS

CENTER

Patient Registration

Please review the information below, fill in any blanks and sign where indicated.

PATIENT NAME | DATE OF BIRTH

ADDRESS

CITY, STATE, ZIP

HOME PHONE | CELL PHONE

WORK PHONE

EMAIL | MARITAL STATUS

SOCIAL SECURITY NUMBER | RACE/ETHNICITY

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN ADDRESS | PRIMARY CARE PHYSICIAN PHONE

PHARMACY NAME & PHONE

EMERGENCY CONTACT | EMERGENCY CONTACT PHONE

HOW WERE YOU REFERRED TO OUR PRACTICE?

I hereby consent to examination and treatment as rendered appropriate by the physician. I hereby authorize the release of information and the records of any treatments or examinations rendered, to other physicians who may be involved in my care, to my insurance company or companies to facilitate billing and directing reimbursement to the physician those insurance benefits to which I am entitled under the terms of my policy, and for quality assurance assessments and physician's certification. I consent to have my medication history accessed. This information is protected under the federal HIPAA regulations and its release is subject to my approval. I understand that this organization may change its Notice of Privacy Practices at any time and that I may request a copy of this policy. Unless otherwise directed below, if I am unavailable, the Physician (or his staff) may communicate test results, and/or information about my care via telephone, voice mail or answering machine to myself or _____ relationship _____.

I authorize benefits to be paid directly to the Physician and I understand that I am responsible for any unpaid balance under the terms of my insurance policy.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN | DATE

111 West Washington • Suite 903 • Chicago, Illinois 60602 • Tel. 312.372.9355 • Fax. 312.372.9356