



MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C.

Osborne Harrison Lee

•Patient Registration Form•

Today's Date: _____ Reason for appointment today: _____

Patient Name: _____
Last First Middle

(Preferred Name) _____

Date of Birth: _____ Age: _____ (Circle-Male or Female) (Circle-Marital Status: S M W D)

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer's Name _____ Title/Position _____ Dept./Ext. _____

Email Address _____ Driver's License # _____ SS # _____

(If married)-Spouse's Name _____ Date of Birth _____ SS # _____

Spouse's Employer _____ Title/Position _____ Work Phone _____

(If minor)-Mom's Name _____ Date of Birth _____ SS # _____

Mom's Employer _____ Title/Position _____ Work Phone _____

(If minor)-Dad's Name _____ Date of Birth _____ SS # _____

Dad's Employer _____ Title/Position _____ Work Phone _____

Emergency Contact Person: _____

(Someone NOT Living With You) First Last (Relationship to Patient)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Insurance Co: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's SS #: _____

Policy / ID #: _____ Group #: _____

Secondary Insurance Co: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's SS #: _____

Policy / ID #: _____ Group #: _____

*Doctor who referred you to our clinic: _____ Is this visit for a second opinion? Y or N

*Is this visit related to an accident? Y or N If yes, please list the accident date _____

*Is this visit a worker's comp. case? Y or N If yes, please list the incident date _____

MISSISSIPPI EAR, NOSE AND THROAT SURGICAL ASSOCIATES, P.C.

•Payment/Insurance Authorization•

By signing below:

·I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to file my insurance for the services received from any physician in this group (which includes C. Michael Osborne, M.D., Scott E. Harrison, M.D., and/or Stephen F. Lee, M.D.).

·I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to receive payment directly for my insurance benefits, including major medical, payable under the terms of my insurance contract.

·I hereby authorize Mississippi Ear, Nose and Throat Surgical Associates, P.C. to release/send any medical information acquired in the course of treatment to my insurance company listed above that is needed for inquiries or to process my claim.

·I hereby authorize photocopies of this form to be valid as the original.

·I hereby agree to be responsible for the payment of this account, including co-pays, deductibles, co-insurance, return check fees and non-covered amounts. Payment is due at the time of service.

Method of Payment: Check _____ Cash _____ Credit Card _____ Debit Card _____

Signature _____ **Date** _____

(If patient is a minor) Patient's Name: _____

•Consent to Treat•

* I _____ do give the listed physicians:
(Name of Patient or Guardian's Name if a Minor)

C. Michael Osborne, M.D., Scott E. Harrison, M.D., Stephen F. Lee, M.D.,

and their staff, permission to administer medical treatment to

myself or my child _____
(Name of Patient)

*** I authorize them to use their medical judgement in the treatment of the (above named patient) so long as myself/he/or she is under their care.**

Patient or Guardian's Signature

Relationship to Patient

Today's Date

Clinic Staff Witness

Today's Date

•OFFICE USE ONLY•

Updated Signature: _____ **Date:** _____