

**Registration:****South Carolina ENT, Allergy, & Sleep Medicine**

Date	Account ID	Chart ID	Other ID	Internal Use
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**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:		How did you hear of us?		
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Pharmacy Phone	

**Physician****Family Physician****Referring Physician****Medical Insurance****Name & Address****Policyholder****Relationship****Policy ID****Group ID**

1							
2							
3							

**Guarantor (Person to be billed, if different than patient)**

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	Email:
City	State	Zip Code	Employer Name & Address			Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:		Work:	Email:
City	State	Zip Code	Employer Name & Address			Occupation

**HIPAA Approved Contacts**

1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
						Work:
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell:
						Work:

**Patient's or Authorized Person's Signature**

I the undersigned give my authorization to treat and assign directly to South Carolina ENT, Allergy, & Sleep Medicine, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date	<b>South Carolina ENT, Allergy, &amp; Sleep Medicine</b> 1165 HWY 1 SOUTH, STE 300 Lugoff, SC 29078	Phone: 803-408-3277 Email: Southcarolinaent.com
X			

Please attach all pertinent insurance ID cards for photocopying.