

REGISTRATION FORM

MAXWELL, KLUGER & MAKARETZ

ENT Associates, MD, PA

43 Baxter Blvd., Portland ME 04101 207-775-6381
586 Alfred Rd., Biddeford ME 04005 207-282-2202
1-800-963-8656

Lynne Lewis, MS, CCC-A
Kelly Lynch, MA, CCC-A
Michael Clark, PA-C
Sandra McCoy, MA, CCC-A

PATIENT INFORMATION

Full Name _____
Mailing Address: _____
City _____ State ____ Zip _____
Home Phone _____
Email Address: _____
Date of Birth _____ Age _____
Sex ___ M ___ F Marital Status ___ M ___ S ___ O
Referring / Family Physician _____
Soc. Sec. # _____
Employer _____
Address _____
Work Phone _____

SPOUSE INFORMATION

Name _____
Address if different _____
Date of Birth _____ SS# _____
Home Phone _____ Work Phone _____
Employer _____
Address _____

PARENT INFORMATION (If patient is a minor child)

Mother's Name _____
Address if different _____
Date of Birth _____ SS# _____
Home Phone _____ Work Phone _____
Employer _____
Address _____
Father's Name _____
Address if different _____
Date of Birth _____ SS# _____
Home Phone _____ Work Phone _____
Employer _____
Address _____

INSURANCE INFORMATION

Primary Ins. Co. _____
Individual's Name _____
Certificate # _____
Group # _____
Subscriber Name _____
Subscriber Date of Birth _____

Secondary Ins. Co. _____
Individual's Name _____
Certificate # _____
Group # _____
Subscriber Name _____
Subscriber Date of Birth _____

Tertiary Ins. Co. _____
Individual's Name _____
Certificate # _____
Group # _____
Subscriber Name _____
Subscriber Date of Birth _____

Worker's Comp? ___ Yes ___ No

Accident? ___ Yes ___ No

Relative or Friend Not Living With You

Name _____

Phone _____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Maxwell, Knowland & Kluger, ENT Associates, MD, PA for any services rendered me. I authorize any holder of medical information about me to be released to ENT Associates, MD, PA and its agents any information needed to determine these benefits or the benefits payable for related services.

Beneficiary
Signature _____

Date _____

I authorize release of medical information necessary, to process any insurance claims. I also authorize assignment of benefits and agree to pay any balance due, not covered by my insurance, to the physicians for the services rendered.

Date: _____

Signature of Patient, Parent or Responsible Party

**PATIENT AUTHORIZATION TO PHYSICIAN
TO DISCLOSE HEALTHCARE INFORMATION**

I, _____, authorize Maxwell, Knowland & Kluger, ENT Associates, MD, PA to disclose my health care information to health care practitioners and health care facilities who are involved in providing my health care and with my family and close friends who are providing me with emotional support as I receive health care services. Also, I authorize Maxwell, Knowland & Kluger, ENT Associates, MD, PA to disclose my health care information to my health insurance carrier, utilization review organization, or benefit manager to support payment for my health care.

My health care information which is the subject of this authorization to disclose includes information, written or not, about the preventive, diagnostic, or treatment services provided to me and that may be used to identify me. Depending upon the services I request from Maxwell, Knowland & Kluger, ENT Associates, MD, PA, this information may include information about treatment for HIV/AIDS, sexually-transmitted diseases, mental health or psychiatric conditions or substance abuse.

This authorization to disclose will remain in effect for 30 months from this authorization unless I revoke it in the manner described below. I can receive a copy of this authorization by asking the office staff.

I understand that I may refuse to disclose all or some health care information and that I may revoke this authorization at any time by providing Maxwell, Knowland & Kluger, ENT Associates, MD, PA with a written, signed and dated request. However, I understand that my refusal to disclose all or some health care information or to provide this authorization at this time or to revoke it later may result in improper diagnosis or treatment, denial of coverage of a claim for health care benefits, or other adverse consequences.

Signature of Patient or Legal Guardian

Date