EASTERN SHORE ENT & Allergy ASSOCIATES, P.A.

JAMES R. GAUL · MICHAEL J. KELLEHER · DANIEL J. KELLEY | M.D., F.A.C.S.
Offices located in Salisbury & Berlin
phone: +1 (410) 742-1567 fax: +1 (410) 742-1906

PATIENT REGISTRATION

(PRINT ONLY, both sides)

____/____/_____
(Today's Date)

Last Name _____ First Name _____ M.I. ___

Street Address _____

City _____ State _____ Zip Code _____

S.S.N. _____-_____-_____ D.O.B ____ /____ /_____ Sex _____ Marital Status _____

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Patient's **Mobile** Phone Number (_____) _____-_____

Patient's **Home** Phone Number (_____) _____-_____

Patient's **E-Mail** Address _____@_____

Patient Employer _____

Work Phone Number (_____) _____-_____

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Primary Care Physician_____

Practice Phone Number (_____) _____-_____

Referring Physician _____

Practice Phone Number (_____) _____-_____

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number (_____) _____-_____

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This section MUST BE COMPLETED if the patient is under 18 OR is not the insured

Insured Parent/Guardian Name _____

Insured's S.S.N. _____-_____-_____ Insured's D.O.B _____ /_____ /_____

Insured's Address _____

Insured's Employer _____

Insured's Work Phone Number (_____) _____-_____

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Emergency Contact _____ Relation _____

Emergency Contact Primary Phone Number (_____) _____-_____

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Would you like to receive text reminders from our practice? Y / N

Would you like to receive automated voice call reminders from our practice? Y / N

Would you like access to the patient portal* (must provide e-mail address)? Y / N

*The patient portal gives you access to certain patient files, visit summaries, upcoming appointment reminders, and messages from our doctors.

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PATIENT AUTHORIZATION

I authorize Eastern Shore ENT & Allergy, P.A (ESENTA) to provide medical care and treatment to myself or patient named above if under the age of 18. I authorize ESENTA to apply for benefits on the patient's behalf for services rendered. I request the insurance make payment directly to ESENTA. I certify that the insurance coverage is correct. I further authorize the release of information, including medical information of any care or treatment of this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing prior to future treatment. My signature below indicates I have read and understand this authorization. I understand and agree to be fully responsible for payment of any service provided, including deductibles, copayments, and non-covered services at the time of service, unless other arrangements have been made.

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Patient Signature (Guardian Signature if patient is under 18) Signature Date

Revised June 2019

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