Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	,
Address:	Relationship to patient: _____
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone: (	Phone: ( ) _____ - _____
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex:	Relationship:
Date of Birth:	Phone:
Social Security No.:	Mobile Phone:( ) _____ - _____
Patient email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language:	Employer:
Race:	Address:
Ethnicity:	Phone:
Marital Status:	

Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for NORTHWEST FLORIDA ENT PA**
- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**
- **I authorize NORTHWEST FLORIDA ENT PA to release medical information required to process my claim**
- **I have read and understand the Financial Policy for NORTHWEST FLORIDA ENT PA**
- **I authorize NORTHWEST FLORIDA ENT PA to obtain/have access to my medication history**
- **I authorize my provider's office to contact me by mobile phone**

I agree to all of the above

Signed_____ **Date:**_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Social Security Number
Patient Address		
,		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. NORTHWEST FLORIDA ENT, PAuses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to NORTHWEST FLORIDA ENT, PA.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to NORTHWEST FLORIDA ENT, PA
3. I have the right to revoke this authorization at any time by writing to NORTHWEST FLORIDA ENT, PA. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE NORTHWEST FLORIDA ENT, PA TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law	Date
Relationship to Patient	Interpreter, if utilized
Witness Signature	