Patient Registration Form
Proctor ENT, PLC

Dr's Conrad A. Proctor MD, & Todd B. Proctor MD
2251 N. Squirrel Road, Ste 105, Auburn Hills, MI 48326
(248) 648-8100 Fax: (248) 648-8060 Web: Proctor-ENT.com

Date: ______________________ Email: ________________________@________________

Name: __________________________________ M F Birth Date: _____________________

Street Address: ____

City: ___________________________________ State: ____________ Zip: _____________

Home Phone: ( ) _______-_______________ **Social Security #: ______-_____-________**

Work Phone: ( ) _______-_______________ Employer: ____________________________

Marital Status: [ ] S [ ] M [ ] W [ ] D [ ] Sep Spouse's Name: _______________________

Emergency Contact (name/phone): ____

Subscriber Information: (*The **Subscriber** is the person whose name is on the original insurance policy.)*

Name: ____
Birth Date: ____
Employer: ____
Relationship to Patient: ___________________________________
Social Security #: ______-_____-________

Billing Address (if different from above): Phone: ( ) _______-___________

Name: ____ Relationship: ___________________________

Address: ____

<u>Assignment of Insurance Benefits</u>: I hereby authorize direct payment of surgical/medical benefits to Dr. Conrad A. Proctor and Dr. Todd B. Proctor for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I agree to be responsible for all collection, court, attorney fees and additional delinquent account billing fees.

<u>Authorization to release information</u>: I hereby authorize Dr. Conrad A. Proctor and Dr. Todd B. Proctor to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

<u>Medicare/Medicaid</u>: I certify that the information given by me in applying for payments is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Signature: ____ Date: ________________________

Circle one: **Patient, Parent or Guardian**