Otolaryngology of Joplin DBA Joplin Ear Nose & Throat
Dr. Renee Walker & Dr. Suzanne Long
1920 E 32nd Street, Joplin Mo 64804
417-781-4613

REGISTRATION INFORMATION

Patient's legal name _____ Date of birth _____

Race _____ Ethnicity _____ Sex _____

Social security # _____ Marital status _____

Mailing address _____ City & State _____ Zip _____

Email address _____ Phone _____ Cell or home _____

Preferred method of contact: Phone Email Letter

Can we leave a detailed message: Yes No

IF PATIENT UNDER AGE 18 OR DISABLED:

Legal guardian name _____ Phone _____

Address _____ City & State _____ Zip _____

Relationship to patient _____

PLEASE LIST AN EMERGENCY CONTACT *OTHER THAN GUARDIAN OR SPOUSE*

Name _____ Relationship _____

Address _____ Phone _____

Primary care physician name & phone# _____

Primary care physician address _____

Referring physician name and phone # _____

Referring physician address _____

How did you hear about our office? Radio Internet

Recommended by someone Insurance Other

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
AUTHORIZATION FOR RELEASE OF INFORMATION

In the course of providing service to you or your dependent, we receive health information. We may use and disclose this health information to other medical professionals for use in the following: 1) to ensure proper treatment of the patient's symptoms and conditions; 2) submission to the insurance company for claims review, determination of benefits and to receive payment for our services rendered to the patient.

In signing this document, you agree that we may use and disclose the patient's health information as indicated above.

I have read this document and understand it. I consent to the use and disclosure of mine / my dependent's health information for the purpose of treatment, administrative functions and service reimbursement. I acknowledge that a copy of the 'Notice of privacy practices' from Joplin Ear Nose & Throat was made available to me for review.

Patient / Legal guardian _____ Date _____

Printed name _____ Relationship _____

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PATIENT / GUARDIAN PERMISSION

Patient name _____ Date of birth _____

As guardian of the above named patient, I authorize the following people to bring him/her to their scheduled appointment:

1. _____
2. _____
3. _____

I authorize the following people to be able to receive medical information on the aboved named patient.

1. _____
2. _____
3. _____

Patient / Legal guardian _____ Date _____