

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	Relationship		
Address	City & State	Zip	
Phone	Date of birth	SSN#	

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 the following: 1) to ensure proper treatment of the patient's symptoms and conditions; and 2) submission to the insurance company for claims review, determination of benefits and to receive payment for our services provided 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 my and/or 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 appointments:

1	Relationship to patient	Birthdate
2	Relationship to patient	Birthdate
3	Relationship to patient	Birthdate

As the patient or legal guardian of the above named patient, I authorize the following people to receive medical information on the above named patient:

1	Relationship to patient	Birthdate
2	Relationship to patient	Birthdate
3	Relationship to patient	Birthdate

Patient / Legal Guardian

Date