OTOLARYNGOLOGY OF JOPLIN DBA JOPLIN EAR NOSE & THROAT
DR. RENEE WALKER, DR. SUZANNE LONG & CAREY SMITH NP
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 | Cell phone | Home phone

Preferred method of contact: Phone call Email Letter

Can we leave a detailed message: Yes No

IF PATIENT UNDER AGE 18 OR DISABLED:

Legal guardian name | Relationship to patient

Address | City & State | Zip

Phone | Date of birth | Social security #

PLEASE LIST AN EMERGENCY CONTACT *OTHER THAN GUARDIAN*

Name | Relationship to patient

Address | Phone

PHYSICIAN INFORMATION

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

Referred by physician TV

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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 _____

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PERMISSIONS

Patient name _____ Date of birth _____

I authorize the following people to be able to **receive patient's medical information:**

1. _____ Relationship to patient _____ Phone # _____
2. _____ Relationship to patient _____ Phone # _____
3. _____ Relationship to patient _____ Phone # _____

IF PATIENT UNDER AGE 18 OR DISABLED:

I authorize the following people to **bring the patient to their scheduled appointment:**

1. _____ Relationship to patient _____ Phone # _____
2. _____ Relationship to patient _____ Phone # _____
3. _____ Relationship to patient _____ Phone # _____

Patient / Legal guardian _____ Date _____