North Kitsap Ear Nose and Throat

DEMOGRAPHIC INFORMATION (PART 1)

Account	Date of Birth	Age	Sex	SSN
Legal Full Name	Preferred Name (if different)		Previous Name(s), if any	
Mailing Address			Email	
Primary #	Secondary #	Work #		Employer
Primary Care Physician		Referring Physician		

INSURANCE (PART 2)

Primary Insurance	Secondary Insurance	Tertiary Insurance
Insurance Name	Insurance Name	Insurance Name
Policy ID	Policy ID	Policy ID
Group or Plan #	Group or Plan #	Group or Plan #
Subscriber | Name	Subscriber | Name	Subscriber | Name
Subscriber | Date of Birth	Subscriber | Date of Birth	Subscriber | Date of Birth

PATIENT HEALTH INFORMATION AUTHORIZATION – ADULT, AGE 18+ (PART 3A)

I authorize the following individuals, to have access to my medical records, including but not limited to appointments and care:

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

PATIENT HEALTH INFORMATION AUTHORIZATION – MINOR, AGE 17 AND UNDER [PARENTS HAVE ACCESS TO RECORDS] (PART 3B)

Minor resides with: ☐ Mother ☐ Father ☐ Mother/Father ☐ other_____

Father's Name_____ Telephone #:_____

Mother's Name_____ Telephone #:_____

In addition to the above listed, the following individuals are authorized to have access to records, including but not limited to appt & care.

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

NOTICE OF PRIVACY PRACTICE | FINANCIAL INFORMATION (PART 4)

- I acknowledge via electronic signature the NKENT Notice of Privacy Practices has been made available for my review.
- I allow NKENT to facilitate the exchange of health records for coordination of care.
- I allow NKENT to contact me via mail/phone, using all numbers in my profile and leave verbal message(s) on voice recorder. ☐ opt out
- I allow NKENT to request medication history from my pharmacy. ☐ opt out

☐ I acknowledge that the NKENT Financial Policy has been available to me. I hereby authorize my insurance benefits to be paid to NKENT. I understand that I am financially responsible for balances including any rebilling. I authorize NKENT and/or insurance carrier to release any information for payment of claims.

☐ I attest that the patient listed above **DOES NOT** have health insurance and will pay for all services rendered by NKENT.

Signature of Patient or Legally Authorized Individual	Name, if Signed on Behalf of the Patient	Date