Benjamin Liess, MD, FACS
Adult and Pediatric Ear, Nose, and Throat
Sinus and Allergy
Head and Neck
Ear and Hearing
Facial Plastic and Reconstructive Surgery

BENJAMIN LIESS MD FACS
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PATIENT REGISTRATION FORM

Name: _____
Date of Birth: _____ ☐ Male ☐ Female
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Ph#: _____
Cell Ph#: _____
Email: _____

Primary Care Physician (PCP): _____
PCP Address: _____
PCP Ph#: _____
Preferred Pharmacy: _____
Pharmacy Ph#: _____
If patient is a child, list parent(s) name (s):
_____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Home Ph#: _____
Cell Ph#: _____
I agree to share my health information with the following people: _____
_____
_____

Based on government regulations, we are required to ask the following:

What is your preferred language? _____
Race: _____ ☐ I prefer not to answer.
Ethnicity: _____ ☐ I prefer not to answer.
Best Form of Contact: ☐ Cell ☐ Home ☐ Email
May we leave a message? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION (Skip if we have a copy of your card)

Primary Ins: _____ Ins #: _____
Policy Holder: _____
Date of Birth: _____
Relationship to Patient: _____
☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: _____ Ins #: _____
Policy Holder: _____
Date of Birth: _____
Relationship to Patient: _____
☐ Self ☐ Spouse ☐ Parent ☐ Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

Name: _____
☐ Male ☐ Female
Date of Birth: _____

☐ Check if same as patient information.
If not, please complete the entire section.
Relationship: _____
Phone #: _____

I acknowledge full financial responsibility for any services rendered, and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. I also understand methods of contact may include prerecorded/artificial voice messages and the use of automatic dialing devices as applicable.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending physician and their associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature: _____
Date: _____

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature: _____
Date: _____