Patient Registration Form
Proctor ENT, PLC

Todd B. Proctor MD
2251 N. Squirrel Road, Ste 105, Auburn Hills, MI 48326
(248) 648-8100 Fax: (248) 648-8060 Web: Proctor-ENT.com

Date: _____ Email: _____@_____

Name: _____ M F Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____

Work Phone: ( ) _____-_____ Employer: _____

Marital Status: [ ] S [ ] M [ ] W [ ] D [ ] Sep Spouse's Name: _____

Emergency Contact (name/phone): _____

Billing Address (if different from above): Phone: ( ) _____-_____

Name: _____ Relationship: _____

Address: _____

Primary Insurance Subscriber Information:
(*The **Subscriber** is the person whose name is on the original insurance policy.)*
Name: _____
Birth Date: _____
Employer: _____
Relationship to Patient: _____

Secondary Insurance Subscriber Information:
Name: _____
Birth Date: _____
Employer: _____
Relationship to Patient: _____

Patient or Authorized Person's Signature: I authorize the release f any medical or other information necessary to process health insurance claims for services rendered by Proctor ENT, PLC physicians and/or office staff. I authorize insurance(s) to make payment directly to Proctor ENT, PLC for services rendered. I accept financial responsibility for payment of deductibles, copays, co-insurances and/or services not covered by my insurance. I agree to be responsible for all collection, court, attorney fees and additional delinquent account billing fees.

Signature: _____ Date: _____
Circle one: **Patient, Parent or Guardian**