



**Cumberland
Otolaryngology
Consultants, PSC**

Kevin T. Kavanagh, M.D.
Board Certified Otolaryngology

402 Bogle St. Suite #3
Somerset, KY 42503

Phone: 606-679-7426

Registration Form

FOR OFFICE USE ONLY: PLEASE COMPLETE					
CHART NO.:					
DATE OF APPOINTMENT:		CLINIC:		DOCTOR:	
PATIENT INFORMATION					
PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)		SEX	DATE OF BIRTH	MARITAL STATUS	RACE
PATIENT ADDRESS		CITY	STATE	ZIP CODE	PATIENT PHONE NUMBER ()
PATIENT EMPLOYER		OCCUPATION & DEPARTMENT			
EMPLOYER ADDRESS		CITY	STATE	ZIP CODE	WORK PHONE NUMBER ()
SPOUSE'S NAME		BIRTH DATE			SOCIAL SECURITY NUMBER
SPOUSE'S EMPLOYER		CITY	STATE	ZIP CODE	HOME PHONE NUMBER ()
EMPLOYER'S ADDRESS		CITY	STATE	ZIP CODE	WORK PHONE NUMBER ()
IF PATIENT IS A CHILD COMPLETE THIS SECTION					
FATHER'S OR GUARDIAN'S NAME		BIRTH DATE			SOCIAL SECURITY NUMBER
HOME ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE NUMBER ()
EMPLOYER'S NAME AND ADDRESS		CITY	STATE	ZIP CODE	WORK PHONE NUMBER ()
MOTHER'S OR GUARDIAN'S NAME		BIRTH DATE			SOCIAL SECURITY NUMBER
HOME ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE NUMBER ()
EMPLOYER'S NAME AND ADDRESS		CITY	STATE	ZIP CODE	WORK PHONE NUMBER ()
Do the parents have joint custody? _____ If the answer is no which has custody? _____					
REFERRING PHYSICIAN NAME		ADDRESS	CITY	STATE	ZIP CODE
WHO MAY WE NOTIFY IN CASE OF EMERGENCY			RELATIONSHIP	PHONE NUMBER	<input type="checkbox"/> WORK <input type="checkbox"/> HOME
INSURANCE INFORMATION					
SUBSCRIBER NAME					
PRIMARY INSURANCE COMPANY		ADDRESS	CITY	STATE	ZIP CODE
PRIMARY INSURED NAME		GROUP NUMBER	POLICY#, ID #, OR CERTIFICATE #		
SECONDARY INSURANCE COMPANY		ADDRESS	CITY	STATE	ZIP CODE
SECONDARY INSURED NAME		GROUP NUMBER	POLICY #, ID #, OR CERTIFICATE #		
DO YOU HAVE MEDICARE?	MEDICARE NUMBER	STATE	DO YOU HAVE MEDICAID <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAID NUMBER	STATE
PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING					
<p>PATIENT RESPONSIBILITIES: I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or responsible party(s) agree to pay reasonable attorney's fee and cost of collection if patient's account is placed in the hands of an attorney for handling PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act, or under other insurance coverage, is correct. I authorize any holder of medical or other information about me to release to S.S.A. or its intermediaries or carriers and/or State in which I reside or its Fiscal Agents, or the insurance company or its representatives, any information needed for this or a related Medicare/Medicaid claim, or other insurance claim. In consideration of services rendered, I transfer and assign to Cumberland Otolaryngology Consultants any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.</p>					
Patient signature (signature by mark must be witnessed)		Responsible party signature		Witness signature	