

Ear, Nose & Throat *SpecialtyCare*

Patient Registration Form

Computer # _____

Today's Date _____ Please Print (If you need help in filling out this form, let our Reception/Business Desk know.)

PATIENT NAME _____
(First) (M) (Last) (Birthdate) (Age)

Address _____
(Street) (Apt. #) (City) (State) (Zip)

Social Sec. # _____ Male _____ Female _____ Home Phone # () _____

Patient's Employment _____ ① Work Phone # () _____

Parent's/Spouse's Name _____ ② Work Phone # () _____

If minor, list both parent's full names _____ Cell Phone # () _____

TO RESPECT YOUR PRIVACY, HOW CAN WE REACH YOU REGARDING YOUR HEALTH INFORMATION, LAB TEST RESULTS, MEDICATION, BILLING?

Choose all that apply:

1) Leave message on voice mail:

Home

Work #1

Work #2

Cell

2) Do not leave message on voice mail:

3) Leave message with: _____

Name

Relationship

X

Signature

For Office use only:

Restrictions _____

Signature _____

PHARMACY PHONE NUMBERS

Who referred you to our office? _____

Referring Physician: _____

Clinic/Address _____

Family Physician: _____

Clinic/Address _____

EMERGENCY CONTACT PERSON OTHER THAN THE ABOVE/BELOW NAMES:

Name _____ Relationship _____ () Home Phone _____ () Work Phone _____

POLICYHOLDERS INFORMATION

Name _____ Soc. Sec. # _____ Relationship _____
(First) (M) (Last)

Address _____
(Street) (Apt. #) (City) (State) (Zip)

Employer _____ Home Phone # () _____

Address _____ Work Phone # () _____

Is this related to an accident? Yes _____ No _____ Auto _____ Work _____ Other _____ Description/Date _____

Primary Insurance _____ **Second Insurance** _____

Name

Name

Group # _____

Group # _____

ID# _____

ID # _____

Policyholder's D.O.B. _____

Policyholder's D.O.B. _____

OFFICE USE

INSURANCE _____

CARE SYSTEM _____

WITHOUT SUFFICIENT VERIFICATION OF CURRENT MEDICAL INSURANCE COVERAGE, PAYMENT IS REQUIRED AT THE TIME OF SERVICE. WE ACCEPT ALL MAJOR CREDIT CARDS.

COPAYS ARE DUE AT THE TIME OF SERVICE.