ENT Ear, Nose & Throat Specialty Care

Patient Registration Form

Date: _____ **Account:** _____

Patient First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Patient Gender: Male ____ Female____ Transgender _____

Patient Address: _____

Street Apt # City State Zip Code

Home Phone: _____ Cell Phone: _____

(Ear, Nose & Throat Specialty Care sends automated voicemail/text reminders to numbers provided)

Email: _____

Parent/Guardian Name: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Pharmacy Name and City: _____ Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Primary Care Physician Clinic: _____ Referring Physician Clinic: _____

Primary *Insurance:* _____

Group Number:_____

Member ID: _____

Policyholder Name: _____

Policyholder Date of Birth: _____

Patient relationship to policyholder: _____

Policyholder Address: _____

City, State, and Zip: _____

Secondary *Insurance:* _____

Group Number: _____

Member ID: _____

Policyholder Name: _____

Policyholder Date of Birth: _____

Patient relationship to policyholder: _____

Policyholder Address: _____

City, State, and Zip: _____

☐ Check box if your visit is due to a motor vehicle accident or a work injury

I authorize Ear, Nose and Throat *Specialty Care* to discuss, and/or leave a voicemail with the following person(s): (this will not be automated) ***Please circle YES or NO***

Name	Relationship	Phone number	Scheduling	Medical	Billing
_____	_____	_____	Y N	Y N	Y N
_____	_____	_____	Y N	Y N	Y N

Print Parent/Guardian Name: _____

Patient/Parent/Guardian Signature & Date _____