

# Patient Registration

Thank you for completing this form.

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_  
*Last Name* *First Name* *Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

In case of emergency who should be notified \_\_\_\_\_  
*Name/Relation to Patient* *Phone*

## INSURANCE INFORMATION

Person Responsible for Account \_\_\_\_\_  
*Last Name* *First Name* *Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec# \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

## ADDITIONAL INFORMATION

By whom were you referred? \_\_\_\_\_

Other Physicians who care for you \_\_\_\_\_

Circle either yes or no for the following questions:

May we leave messages on your answering machine? YES NO May we call you at work? YES NO

May we release information to your spouse? YES NO

## ASSIGNMENT OF BENEFITS

I hereby give indefinite authorization for payment of insurance benefits to be made directly to Ear Nose & Throat Specialists, Inc. for services provided. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize the release of all information necessary to secure the payment of benefits. **I understand that failure to provide this office with current insurance information may result in my being responsible for all charges.**

Signature of Patient, Legal Guardian, or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_