AFFILIATED EAR, NOSE AND THROAT PHYSICIANS

PATIENT REGISTRATION

Date:_____

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ SS #:_____ ❒Male ❒ Female

Street: _____ City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ E-Mail Address:_____

Employed: ❒ Full Time ❒ Part Time ❒ Retired ❒ Not Student: ❒ Full Time ❒ Part Time

Patient's Employer: _____ Occupation: _____

Street: _____ City: _____ State: _____ Zip: _____

Work #:_____ May we contact you at work? ❒ Yes ❒ No

❒ Single ❒ Married ❒ Divorced ❒ Legally Separated ❒ Widow

Spouse's Name: _____ SS#:_____ Date of Birth: _____

Employer: _____ Occupation: _____

Work #:_____ May we contact them at work? ❒ Yes ❒ No

Emergency Contact: _____ Relationship: _____ Phone #:_____

Parent's info <u>(if under 18)</u>: Mom's Name: _____SS #:_____

Street:_____City:_____State:_____Zip:_____

Home #:_____ Date of birth:_____ E-mail address:_____

Employer: _____ Occupation: _____Work #:_____

May we contact them at work? ❒ Yes ❒ No

Dad's Name:_____SS#:_____Street:_____

City:_____State:_____Zip:_____Home #:_____

Date of birth:_____ E-mail address:_____

Employer: _____ Occupation: _____Work #:_____

May we contact them at work? ❒ Yes ❒ No

Primary Insurance Company/Insured Party:

Insurance Company: _____

Policyholder: ❒ Self ❒ Spouse ❒ Parent ❒_____

Name: _____

Date of Birth: _____

Secondary Insurance Company/Insured Party:

Insurance Company: _____

Policyholder: ❒ Self ❒ Spouse ❒ Parent ❒_____

Name: _____

Date of Birth: _____

How were you referred to us? ❒Physician_____
Name Specialty

❒Yellow Pages ❒Internet ❒Walk-In ❒Other _____

FOR OFFICE STAFF ONLY:

Patient Account #:_____

Initials:_____