PATIENT REGISTRATION
Please Print All Information

Patient Name (Last, First, Initial)_____________________________________ Date____________
Home Address ____
City, State, Zip ____
Social Security # ___________________ Date of Birth______________Age ________________
Home Phone # _______________________ Mobile Phone # _____________________________

Would you like to be included in our email list regarding Cosmetic Specials and updates: ___Yes ____ No?

How did you hear about our practice? ____

Work Phone # ________________________ Email ____________________________________
Sex ___M___F Race___________________ Language: English______ Other _____________
Ethnicity (please choose one) Hispanic or Latino ____________________ Other _____________
Pharmacy Name/Location ____________________________ Secondary____________________
Referring Doctor ________________________ Primary Doctor __________________________
Employer_______________________________________Occupation________________________
Responsible Party/Guardian (if minor)_______________________ Phone #__________________
Emergency Contact Person _______________________________ Phone #__________________
Is your present condition: Auto Related? ________________ Workers Comp? _______________

INSURANCE INFORMATION

Insurance Company ____
ID # __________________________________ Group # ______________________________
Address ____
Policyholder's Name ___________________________________Date of Birth _______________
Relation to Patient ____

SECONDARY INSURANCE INFORMATION

Insurance Company ____
ID # ____________________________________ Group # ____________________________
Policyholder's Name __________________________________ Date of Birth ________________
Relation to Patient ____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Providence ENT to furnish information to insurance carriers concerning my illness and treatments, and hereby assign to the physicians all payments for my medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by my insurance.

Signature ____ **Date**________________________

11/2103