

The Ear Nose and Throat Clinic & Hearing Center
Patient Registration

Account No. _____ Date _____
Patients Name _____ Birthdate _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Employer _____
Sex M F Marital Status S M D W Spouses Name _____
Home Phone () _____ Work Phone () _____
Email _____
Referring Physician _____ Referring Clinic _____
If not referred, how did you hear about us?
 Friends/Family Insurance Company Yellow Pages Website Sign
 Other, (Please name) _____
If Minor, Parent's Name _____ Second Parent's Name _____

Person responsible for charges (if other than patient) _____
Address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____
Relationship to patient _____ Home Phone () _____
Social Security # _____ Work Phone () _____

Emergency Contact _____ Phone () _____
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance

Policy Holder Name _____
Insurance Company _____
Address _____

Phone () _____
Effective Date _____
ID/Contract# _____
Group/Plan# _____

Secondary Insurance

Policy Holder Name _____
Insurance Company _____
Address _____

Phone () _____
Effective Date _____
ID/Contract# _____
Group/Plan# _____

I authorize treatment of the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical benefits to be made directly to The Ear, Nose and Throat Clinic and Hearing Center.
I authorize the release of correspondence and/or medical records to other medical providers involved in my child's care.
I have read and understand the Financial policy.

Signature _____ Date _____