PATIENT REGISTRATION

EAR NOSE & THROAT CLINIC

PATIENT NAME: _____
ADDRESS:

_____

_____

D.O.B:_____ SS#: LEAVE BLANK PREFERRED LANGUAGE:_____
ETHNICITY&RACE: _____
RESPONSIBLE PARTY: _____

PHONE# :_____(H)_____(C)_____(W)
PLEASE SELECT PREFFERED PHONE # TO CONTACT

INSURANCE INFO-
CARRIER:_____
ADDRESS:_____
PHONE #:_____
GROUP #:_____
I.D#:_____

IF CHILD RESPONSIBLE PARTY OR INSURANCE SUBSCRIBER
NAME: _____ D.O.B:_____
SS#: PLEASE LEAVE BLANK
WORK: _____

EMERGENCY CONTACT: _____PHONE#: _____

DRUG ALLERGIES: _____ PHARMACY:_____

SIGNATURE: _____DATE: _____

To send your completed form electronically, use the "Submit Via Email" button OR save this form and attach the saved file to a new email message to entscheduler@gci.net. If you prefer to fax this form, please use the "Print & Fax" button.

SUBMIT VIA EMAIL PRINT & FAX