

### Patient Registration

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_  
Number and Street Apt# City State Zip

Date of Birth: mo \_\_\_ day \_\_\_ yr \_\_\_ Marital Status: S M W D Sex: M F

SS#: \_\_\_ - \_\_\_ - \_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Driver's Lic #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouses Name: \_\_\_\_\_ Spouses Phone #: \_\_\_\_\_

Referred By: \_\_\_\_\_ ENT or Internist: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ ID# \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holders Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

**\*\* Give your insurance cards to the front desk for copying\*\***

If someone other than yourself is responsible for payment please complete the following:

Name of Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I understand that all services are to be paid in full at the time they are rendered, unless prior arrangements are made. I understand that I am personally responsible for payment of all charges. This office will provide me with receipts for my filling insurance claims. A service fee of 1 ½ % per month (18% per annum) will be charged on the unpaid principal balance on all accounts not paid within 60 days of date of service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_