Community ENT & Allergy

**Patient Registration**

**Patient Information**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_ Nickname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Home Phone# (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone# (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Method: Patient Portal \_\_\_ Phone \_\_\_ Email \_\_\_

Preferred Phone Contact: Home \_\_\_ Mobile \_\_\_ OK TO LEAVE DETAIL MESSAGE: YES / NO

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ⃝ Married ⃝Single ⃝Divorced ⃝Widowed Primary Language: ⃝English ⃝Spanish ⃝Other\_\_\_\_\_ ⃝Decline to answer

Race: ⃝African Amer/Black ⃝Amer Indian/Alaska Native ⃝Caucasian/White ⃝Hispanic/Latino ⃝Asian ⃝Other ⃝Decline to answer

Ethnic Group: ⃝Hispanic or Latino ⃝Not Hispanic or Latino ⃝Unknown ⃝Decline to answer

EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\* For Minors \*\*\*\***

Guardian/Parent Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Social Sec #\_\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (If different from patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physicians**

Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**

**Primary** Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary** Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Relation to patient\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my consent to the physicians at Community ENT & Allergy to examine & render treatment as appropriate for the above named patient.

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all/any balance. I authorize Community ENT & Allergy, PLLC or insurance company to release any information required to process my claims.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Parent/Guardian Date Signed