



Carolina Ear, Nose & Throat Head and Neck Surgery Center

PATIENT REGISTRATION FORM MAR/06

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ Address: _____

City, State, Zip: _____ Ref. Phys.: _____

Date of Birth: _____ Sex: M F Marital Status: S M W D SEP

Home Phone: _____ Employer: _____

Cell Phone: _____ Does patient live at a Skilled Nursing Facility: Y N

Work Phone: _____ ext. _____

How did you hear about us? _____

Email Address: _____

BILLING AND INSURED INFORMATION (complete this section if the Insurance is in someone, other than the patient's name):

Last Name: _____ First Name: _____ MI: _____

SS#: _____ Address (**if different**) _____

City, State, Zip: _____

DOB: _____ Employer: _____ Wk#: _____

PARENT INFORMATION (please complete if patient is a minor):

Name: _____ SS#: _____

DOB: _____ Employer: _____ Wk#: _____

IN CASE OF AN EMERGENCY CONTACT:

Name: _____ Relation: _____ Phone: _____

I, being the patient or guardian do hereby request and authorize Carolina Ear, Nose & Throat Head and Neck Surgery Center, P.A. and their staff to perform necessary services to myself or my dependents, including, but not limited to, x-rays and administration of anesthetics which are deemed advisable by the physician. I also authorize Carolina Ear, Nose & Throat Head and Neck Surgery Center, P.A. to release any information required in the course of my examination to my physician and or insurance company. I understand that I am responsible for any amount not covered by insurance. I also understand that if my account has to be turned over to a collection agency I will be responsible for a \$100.00 non-refundable fee and will result in the termination of the physician/patient relationship.

DATE: _____ SIGNATURE: _____

*This information contained is **CONFIDENTIAL AND PRIVILEGED.***