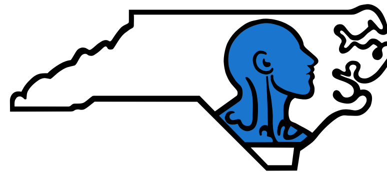
Pt. #________________

Dr. # _______________

Loc. # ______________

Date: _______________



Carolina Ear, Nose & Throat Head and Neck Surgery Center

PATIENT REGISTRATION FORM

Last Name: ________________________ First Name: ______________________ MI: _______

SSN#: ___________________ Address: ____

City, State, Zip: _______________________________ Ref. Phys./Primary Phys: _______________________

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

Race: ______________________ Language Spoken: __________________________

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino Refused to Report

Home Phone: ___________________ Employer: ____________________________________

Cell Phone: _____________________ Work Phone: ______________________ ext._____________

Email Address: ____

How did you hear about us? _______________________________

Does patient live at a Skilled Nursing Facility: Y N
(If yes, Facility Name ___________________ Facility Phone # _________________________

IN CASE OF AN EMERGENCY CONTACT:

Name: ____________________________ Relation: _____________ Phone:___________________

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#: ___________________

I, being the patient or guardian do hearby 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 **$150.00** non-refundable fee and will result in the termination of the physicican/patient relationship.

DATE: _______________ **SIGNATURE**:____