

# REGISTRATION FORM

Ear, Nose and Throat Clinic of the Northwest

**ALL LINES MUST BE FILLED OUT – PLEASE PRINT**

**PATIENT INFORMATION:** Today's Date: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  SS# \_\_\_\_\_

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

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ Cell ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Have you been a patient at Vancouver ENT in the past? Y  N  If so, when? \_\_\_\_\_

What other family members have been patients at Vancouver ENT? \_\_\_\_\_

How did you hear about Vancouver ENT? Newspaper Ad  Phone book  Friend  PCP  Other \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION:** Patient  Parent/Guardian  Spouse  Other \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female  SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ Cell ( \_\_\_\_\_ ) \_\_\_\_\_

Marital Status: \_\_\_\_\_ Full Name of Responsible Party's Spouse: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Ph ( \_\_\_\_\_ ) \_\_\_\_\_

**How will you be paying for today's visit? Cash/Ck/Credit Card  Insurance  Medical Coupon/Medicaid**

If You have an **HMO** or **MANAGED CARE** Insurance, **Did you obtain a referral?** Yes  No

**IF YOU HAVE NOT OBTAINED A REFERRAL PLEASE SEE RECEPTIONIST IMMEDIATELY**

**PRIMARY INSURANCE INFO:**  Managed Care/HMO  Commercial/PPO  Workers Comp (L&I)  
 Medical Coupon  Medicare  Other \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Approximate Effective Date: \_\_\_\_\_

Subscriber/Name of Insured: \_\_\_\_\_ SS# \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Date of Birth of Subscriber/Insured:** \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ Cell ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

How are you related to the patient: \_\_\_\_\_

**SECONDARY INSURANCE INFO:**  Managed Care/HMO  Commercial/PPO  Medical Coupon  
 Medicare  Other \_\_\_\_\_

Name of Insurance: \_\_\_\_\_ Approximate Effective Date: \_\_\_\_\_

Subscriber/Name of Insured: \_\_\_\_\_ SS# \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Date of Birth of Subscriber/Insured:** \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_ Cell ( \_\_\_\_\_ ) \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

How are you related to the patient: \_\_\_\_\_

**EMERGENCY CONTACT:** Name: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_