

REGISTRATION FORM

VANCOUVER EAR NOSE AND THROAT

ALL LINES MUST BE FILLED OUT

PLEASE PRINT

PATIENT INFORMATION

Today's Date _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: Male Female SS# _____

Address: _____ City: _____ State: _____ Zip code: _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Employer: _____ Email: _____

Referring Doctor: _____ Primary Care Doctor: _____

Have you ever been a patient at Vancouver ENT in the past? Yes No If so, when? _____

What other family members have been patients at Vancouver ENT? _____

How did you hear about Vancouver ENT? Newspaper Ad Phonebook Friend PCP Other

RESPONSIBLE PARTY INFORMATION: Patient Parent/Guardian Spouse Other _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: Male Female SS# _____

Employer: _____ Email: _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

Marital Status: _____ Full Name of Responsible Party's Spouse: _____

Spouse's Employer: _____ Spouse's Work Phone () _____

How will you be paying to today's visit? Cash/Ck/Credit Card 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 THE RECEPTIONIST IMMEDIATELY

PRIMARY INSURANCE INFO: Managed Care/HMO Commercial/PPO Worker's 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 Phone () _____ Cell Phone () _____

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 Phone () _____ Cell Phone () _____

Employer: _____ Email: _____

How are you related to the patient? _____

EMERGENCY CONTACT: Name: _____ Phone () _____