BAY AREA ENT SPECIALISTS
REGISTRATION FORM

*****ONLY THE PARENT OR LEGAL/GUARDIAN CAN BRING A MINOR TO THE APPOINTMENT*****

*****NOTE: THE PARENT WHO BRINGS A CHILD TO THE OFFICE FOR MEDICAL TREATMENT IS RESPONSIBLE AT THE TIME OF SERVICE FOR CO-PAYMENT, CO INSURANCE, DEDUCTIBLES AND ACCOUNT BALANCES*****

PATIENT REGISTRATION

Name (Last):______________________ (First):______________________ M__________

Sex: M F Date of Birth:______________ Age:________ SS#______________________

Marital Status: S M Other______________

Street Address:______________________ City:______________ State________ Zip________

Billing Address:______________________ City______________ State________ Zip________

Home Phone:______________ Work:______________ Cell______________

Email:______________________ Employer:______________________

Family Doctor:______________________ Referring Doctor:______________________

Pharmacy:______________ Location:______________ Phone:______________

Emergency Contact Name______________ Phone______________ Relationship______________

Primary Insurance:______________ Subscriber name:______________ DOB:______________

Relationship to Patient:______________ SS#______________ Employer Name:______________

Secondary Insurance:______________ Subscriber Name;______________ DOB:______________

INFORMATION REQUESTED BY THE FEDERAL GOVERNMENT

Language:______________ Ethnicity: Hispanic___ Not Hispanic________ Refuse to Report_____
Race: American Indian________ Asian________ Black or African American____ Hispanic_____
Other Pacific Islander________ White_______ Refuse to Report____________

IF PATIENT IS A MINOR
PARENTAL /LEGAL GUARDIAN INFORMATION

Name (Last):______________________ (First)______________ Relationship:______________

Address:______________________ City______________ State________ Zip______________

Home Phone:______________ Work______________ Cell______________

Employer/Phone:____

Sign:______________________ **Date:**______________________