West Michigan Ears, Nose & Throat - PATIENT REGISTRATION FORM

Patient Information:

Last Name _____ First Name _____ MI____

Address _____ City _____ State _____ Zip _____

Home Phone _____Work Phone _____Cell/Daytime Phone _____
Can this # receive text messages? Y / N

SSN _____ Date of Birth_____ Age _____ Sex M / F Marital Status : S M D W

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

E-mail Address_____

Employer _____ Full-time / Part-time (circle one) Occupation: _____

If student: Full-time / Part-time (circle one)

Family Doctor _____ Referring Doctor (if different) _____

Emergency Contact _____

Relationship to Patient _____ Phone # _____

Spouse/Parent/Legal Guardian Information:

Name _____Phone # _____Relationship _____

Primary Insurance Information:

Subscriber Name _____D.O.B _____ SS#_____

Insurance Co. Name _____ Employer Name _____

Insurance Co. Address_____ Insurance Co. Phone #_____

Policy #_____ Group Name (if applicable)_____ Group # (if applicable)_____

Effective Date_____ Specialist Co-pay Amount:_____ Deductible Amount_____

Secondary Insurance Information:

Subscriber Name _____D.O.B _____ SS#_____

Insurance Co. Name _____ Employer Name _____

Insurance Co. Address_____ Insurance Co. Phone #_____

Policy #_____ Group Name (if applicable)_____ Group # (if applicable)_____

Effective Date_____ Specialist Co-pay Amount:_____ Deductible Amount_____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Patient/Guardian Signature _____ Date _____

Relationship if patient is a minor _____