Allergy & Sinus Disease
ENT Surgery
Hearing Exams & Hearing Aids
Thyroid & Parathyroid Surgery

New Patient Registration Date: __________/__________/__________

Reason for today's visit: ____

Do you have any scans/labs related to this? ____

First Name: ____________________________ MI: ____ Last Name: ___________________________________

SSN: ___________-___________-____________ Date of Birth: __________/__________/___________

E-Mail: ____

(Your e-mail gives you access to the patient portal on our website to access/update your medical records.)

Street Address: ____

City: ____ State: __________ Zip Code: __________________

Home: (______) _______-_________ Cell: (______) ________-________ Work: (______) ________-________

Pharmacy Name: __________________________________ City: ________________________ State: _______

Primary Care Provider's Name: ____

City: _______________________________________ State: _________ Phone: (_______) ________- __________

Referring Provider's Name: ____

City: _______________________________________ State: _________ Phone: (_______) ________- __________

Language: ____

Race: White_____ Black / African American_____ Asian_____ American Indian/Alaska Native_____ Native Hawaiian/Other Pacific Islander _____ Other______________________________

Ethnicity: Hispanic or Latino_____________ Not Hispanic or Latino _____________

Insurance Name(s): ____

Is the patient the insurance policy holder? Yes: ________ No: ________

Insured's Name: _______________________________________ Relationship to Patient: __________________

SSN#: ________-________-_________ Date of Birth: ________/________/_________

Street Address (if different from patient's): ____

City: ____ State: _________ Zip Code: ________________

Phone Number: (________) _________-__________

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