The Ear, Nose and Throat Clinic & Hearing Center
Patient Registration

Patient Name: ____
(First Name) (MI) (Last Name)

Date of Birth: _______________ Sex: ❑ M ❑ F Social Security Number: ____________________

Address: ____ Apt/Unit: _____________

City: ____________________________________ State: ______________________ Zip Code: _________

Home Phone: (_____) ____________________ Cell Phone: (_____) ____________________

Work Phone: (_____) ____________________

Email: ____

Insurance Information:

Primary Insurance Company: ____

Policy Holder: ____________________________________ Date of Birth: ________________________

If Patient is a minor:

Parent or Legal Guardian: ____

Date of Birth: _______________ Sex: ❑ M ❑ F Social Security Number: ____________________

Address: ____ Apt/Unit: _____________

City: ____________________________________ State: ______________________ Zip Code: _________

Home Phone: (_____) ____________________ Cell Phone: (_____) ____________________

Work Phone: (_____) ____________________

Email: ____

I have verified the information above is correct.

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Signature **Date**