Feldman ENT Group, P.C.

ADULT PATIENT REGISTRATION

PLEASE PRINT-FILL ALL AREAS

PATIENT #:
MR LOC:

PATIENT INFORMATION

Last Name	MI	First Name	Date of Birth	Age	Sex

Home Address	City	State	Zip

Home Phone Number	Work Phone Number	Cell Phone Number

SSN	Email Address

Marital Status □ SINGLE | □ MARRIED | □ PARTNER | □ DIVORCED | □ WIDOWED	Spouse/Partner Name

Employer	Occupation

EMERGENCY CONTACT_____ PHONE_____

PRIMARY PHYSICIAN _____ PHONE_____

REFERRING PHYSICIAN_____ PHONE_____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

PRIMARY INSURANCE AND POLICY HOLDER INFORMATION

Policy Holder's Name	□ Male □ Female	Relationship to Patient	SSN

Primary Insurance Co.	Co-Pay	Date of Birth	Policy Effective Date

Insurance Address	ID Number	Group Number

City	State	Zip	Insurance Phone No. for Eligibility/Verification

SECONDARY INSURANCE POLICY HOLDER INFORMATION

Policy Holder's Name	□ Male □ Female	Relationship to Patient	SSN

Primary Insurance Co.	Co-Pay	Date of Birth	Policy Effective Date

Insurance Address	ID Number	Group Number

City	State	Zip	Insurance Phone No. for Eligibility/Verification

I certify that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor, I have read, understand, and fully accept the *Conditions of Registration* form.

SIGNATURE **PRINT** **DATE**

OVER

Feldman ENT Group, P.C.

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The below information is required as part of the PPACA (Patient Protection and Affordable Care Act) and requested by the U.S. Government

Race:

_____ American Indian or Alaskan
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other
_____ Refuse to Report/Unreported
_____ White

Ethnicity:

_____ Hispanic or Latino
_____ Non Hispanic or Latino
_____ Refuse to Report/Unreported

Languages:

_____English
_____French
_____German
_____Japanese
_____Mandarin
_____Russian
_____Spanish

I certify that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor, I have read, understand, and fully accept the *Conditions of Registration* form.

SIGNATURE **PRINT** **DATE**