Feldman ENT Group, P.C.

PATIENT REGISTRATION

PLEASE PRINT-FILL ALL AREAS

PATIENT INFORMATION

Last Name	MI	First Name	Date of Birth	Age	Sex

Home Address	City	State	Zip

Home Phone Number	SSN

EMERGENCY CONTACT_____ PHONE_____

PRIMARY PHYSICIAN_____ PHONE_____

REFERRING PHYSICIAN_____ PHONE_____

Pharmacy Name/Address _____

Pharmacy Phone Number: _____

EMAIL ADDRESS FOR APPOINTMENT NOTIFICATION

PARENT INFORMATION

LEGAL CUSTODY: □ JOINT (MARRIED) | □ JOINT (DIVORCED) | □ MOTHER | □ FATHER

□ Mother □ Father	First Name	MI	Last Name	Date of Birth

Home Address (□ Same)	City	State	Zip

Employer	Occupation	Home Phone Number	Work Phone Number

□ Mother □ Father	First Name	MI	Last Name	Date of Birth

Home Address (□ Same)	City	State	Zip

Employer	Occupation	Home Phone Number ( )	Work Phone Number ( )

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

OVER

Feldman ENT Group, P.C.

PATIENT REGISTRATION

PLEASE PRINT-FILL ALL AREAS

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**