TRI-STATE OTOLARYNGOLOGY
HEAD AND NECK SURGERY, INC.

REGISTRATION FORM 1 DATE ____________________

PATIENT LAST NAME			FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER	BIRTH DATE	AGE	PATIENTS CELLULAR NO. ( )		HOME TELEPHONE NO. ( )
MAILING ADDRESS	CITY	STATE	ZIP CODE		REFERRING PHYSICIAN
DRIVER'S LICENSE NO.	SEX M F	MARITAL STATUS S M Div. Wid.			FAMILY PHYSICIAN
EMPLOYED BY	EMPLOYER'S ADDRESS		OCCUPATION		BUS. PHONE
SPOUSE'S NAME	EMPLOYED BY	EMPLOYER'S ADDRESS			BUS. PHONE
NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU		RELATIONSHIP TO PATIENT			PHONE NO.
NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU		RELATIONSHIP TO PATIENT			PHONE NO.

RESPONSIBLE PARTY: Please complete the section below if the patient is under 18 yrs. of age.

NAME OF RESPONSIBLE PARTY	STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE NUMBER ( )	RELATIONSHIP TO PATIENT		DRIVER'S LICENSE NO.	
EMPLOYER	EMPLOYER'S ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	BIRTH DATE		BUSINESS PHONE	

INSURANCE CARRIER(S) INFORMATION					
PRIMARY	LAST NAME	FIRST NAME	M. INITIAL	DOB	SOCIAL SECURITY #
SECONDARY	LAST NAME	FIRST NAME	M. INITIAL	DOB	SOCIAL SECURITY #

OFFICE POLICY: Our office will file your Primary insurance. Your Secondary insurance will be billed for surgeries only. You must provide us with current card(s). All co-pays and deductibles are due on day of service. If your insurance requires a referral, we must have the referral that day or you will need to reschedule your appointment. Private-pay patients are required to pay a $90 deposit.

INSURANCE AUTHORIZATION: I, hereby authorize TRI-STATE OTOLARYNGOLOGY to release to my insurance any and all information contained in my records. I also authorize assignment and payment directly to TRI-STATE OTOLARYNGOLOGY.

I have received a copy of the "Notice of Privacy Practices".

SIGNATURE: ______________________________ RELATIONSHIP TO PATIENT: ____________________

ARE HEARING LOSS, NOISE IN THE EARS, OR DIZZINESS YOUR PRIMARY PROBLEM? YES NO