

SOUTHDALE OTOLARYNGOLOGY, PA
Adult Patient Registration

Account No. _____ Date _____
Patient's Name _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Employer/Occupation _____
Gender M F Marital Status _____
Home Phone (____) _____ Work Phone (____) _____
Referring Physician _____ Referring Clinic _____

Spouse/Partner Name _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Employer/Occupation _____
Home Phone (____) _____ Work Phone (____) _____

Emergency Contact _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance

Policy Holder Name _____
Insurance Co _____
Address _____

Phone (____) _____
Effective Date _____
ID/Contract # _____
Group/Plan # _____

Secondary Insurance

Policy Holder Name _____
Insurance Co _____
Address _____

Phone (____) _____
Effective Date _____
ID/Contract # _____
Group/Plan # _____

I authorize medical treatment of the above patient.
I authorize the release of medical records necessary to process insurance claims.
I am responsible to pay for all services received, regardless of insurance coverage.
I authorize payment of medical benefits to be made directly to SOUTHDALE OTOLARYNGOLOGY, PA.
I authorize the release of correspondence and/or medical records to other medical providers involved in my care.
I have read and understand the Financial Policy.

Signature _____ Date _____

Relationship to Patient _____