REGISTRATION FORM
VANCOUVER EAR NOSE AND THROAT

ALL LINES MUST BE FILLED OUT **PLEASE PRINT**

PATIENT INFORMATION: **Today's Date:**______________________________

Last Name:_________________________________ First:____________________________________ MI:_________________

Date of Birth: _______________ Age: ____________ Sex: ☐ Male ☐ Female SS#_________________________________

Address:________________________________City:_________________________ ST:__________Zip:_________________

Home phone( )__________________Work( )______________________Cell( )__________________________

Employer:____Email:____

Referring Doctor:____________________________________ Primary Care Doctor:_________________________________

Have you been a patient at Vancouver ENT in the past? ☐ Y ☐ N If so when?______________________________________

What other family members have been patients at Vancouver ENT?____

RESPONSIBLE PARTY INFORMATION: ☐ Patient ☐ Parent/Guardian ☐ Spouse ☐ Other________________

Last Name:_________________________________ First:___________________________ MI:_______________________

Date of Birth: _______________ Age: ____________ Sex: ☐ Male ☐ Female SS#_______________________________

Employer:_______________________________________Email:____

Home phone( )__________________Work( )___________________________Cell( )________________

Full Name of Responsible Party's Spouse____

Spouse's employer____Spouse's work ph ( )________________________

How will you be paying for today's visit? ☐ Cash/Ck/Credit Card ☐ Insurance ☐ Medical Coupon/Medicaid

IF HMO OR MANAGED CARE: **Did you obtain referral? ☐ Yes ☐ No**
IF YOU HAVE NOT OBTAINED A REFERRAL PLEASE SEE RECEPTIONIST IMMEDIATELY

PRIMARY INSURANCE INFO: ☐ Managed Care/HMO ☐ Commercial/PPO ☐ Workers Comp(L&I)
☐ Medical Coupon ☐ Medicare ☐ Other______________________

Name of Insurance: ___________________________________ Approxmate Effective Date: _________________________
Subscriber/Name of Insured:____SS#:__________________________________
ID Number_______________________________________Group Number:______________________________________
Date of Birth of Subscriber/Insured:____
Home phone( )__________________Work( )___________________________Cell( )___________________
Employer:____ Email____
How are you related to the patient:____
SECONDARY INSURANCE INFO: ☐ Managed Care/HMO ☐ Commercial/PPO ☐ Medical Coupon
☐ Medicare ☐ Other____
Name of Insurance: ___________________________________ Approximate Effective Date: ________________________
Subscriber/Name of Insured:____________________________SS#:____
ID Number_______________________________________Group Number:______________________________________
Date of Birth of Subscriber/Insured:____
Home phone( )_____________________Work( )______________________Cell( )_____________________
Employer:____ Email____
How are you related to the patient:____
EMERGENCY CONTACT: Name___________________________________ Phone( )___________________________

I have read this financial policy and understand that, regardless of any insurance coverage I may have, I am financially responsible for Payment of medical services rendered.

___________________________________ ____________________________
Patient Signature **Date**