PRINCETON OTOLARYNGOLOGY

Patient Registration Form

Patient Acct #: _____

PATIENT

Patient's Name: Last | First *(legal)*: | Middle Initial:

Address:

City: | State: | Zip:

Sex: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SSN#: | Date of Birth: | Age:

Home Phone # | Work # | Ext # | Cell #

Employer: | Occupation:

Email Address:

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

Race
☐ White
☐ Asian
☐ Pacific Islander
☐ Black/African American
☐ Native Hawaiian
☐ American Indian or Alaskan Native
☐ More than one race
☐ Unreported/Refused to Report

How would you like to receive appointment reminders?
☐ Postal ☐ Phone
☐ WEB Portal

Preferred Language:
_____

Pharmacy Name: | Street/City:
Phone:

Mail Order Pharmacy Name: | Phone:

Family Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Emergency Contact Name: | Phone: | ☐ Home
☐ Work ☐ Cell

**** Please present your insurance card to the receptionist ****

INSURANCE

Primary Insurance: _____ ID#: _____ GRP# _____

Subscriber's Name: _____ DOB _____ SSN _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Secondary Insurance _____ ID#: _____ GRP#: _____

Subscriber's Name: _____ DOB: _____ SSN: _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Has a Worker's Compensation claim been filed for this injury? ☐ Yes ☐ No If Yes, Date of Injury:
_____

Nurse Case Manager Name & Phone: _____ Adjuster Name & Phone:
_____

*Approval must be given by your employer, Nurse Case Manager or Adjuster **before** your appointment. All appointments made without prior approval will be rescheduled.

FINANCE

Responsible Party (for patients who are under age 18)
Name-Last: | First: (legal) | Middle Initial:

Address: (if different than patient)

City: | State: | Zip:

SSN#: | Date of Birth:

Phone #: | Relationship to patient: ☐ Father ☐ Mother ☐ Guardian