AIRWAY ALLIANCE ENT
REGISTRATION FORM

*****ONLY THE PARENT OR LEGAL/GUARDIAN CAN BRING A MINOR TO THE APPOINTMENT*****

*****NOTE: THE PARENT WHO BRINGS A CHILD TO THE OFFICE FOR MEDICAL TREATMENT IS RESPONSIBLE AT THE TIME OF SERVICE FOR CO-PAYMENT, CO INSURANCE, DEDUCTIBLES AND ACCOUNT BALANCES*****

PATIENT REGISTRATION

Name (Last):_____(First):_____M_____

Sex: M F Date of Birth:_____ Age:_____ SS#_____

Marital Status: S M Other_____

Street Address:_____ City:_____ State_____ Zip_____

Billing Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Work:_____ Cell_____

Email:_____ Employer:_____

Family Doctor:_____ Referring Doctor:_____

Pharmacy:_____ Location:_____ Phone:_____

Emergency Contact Name_____ Phone_____ Relationship_____

Primary Insurance:_____ Subscriber name:_____ DOB:_____

Relationship to Patient:_____ SS#_____ Employer Name:_____

Secondary Insurance:_____ Subscriber Name;_____ DOB:_____

INFORMATION REQUESTED BY THE FEDERAL GOVERNMENT

Language:_____ Ethnicity: Hispanic___ Not Hispanic_____ Refuse to Report_____
Race: American Indian_____ Asian_____ Black or African American____ Hispanic_____
Other Pacific Islander_____ White_____ Refuse to Report_____

IF PATIENT IS A MINOR
PARENTAL /LEGAL GUARDIAN INFORMATION

Name (Last):_____ (First)_____ Relationship:_____

Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Work_____ Cell_____

Employer/Phone:_____

Sign:_____ **Date:**_____