PATIENT REGISTRATION

Patient Name: _____ **Date of Birth:**_____/_____/_____
First Middle Last Suffix

Patients Age: _____ **Sex:** Male ☐ Female ☐ **Race (Optional)** : _____ **SSN:** _____

Marital Status: _____ **Phone Number**: ☐ Cell ☐ Home _____

Address :_____**City, State:** _____ **Zip Code**:_____

Email Address: _____ ☐ **Check to enroll in our patient portal**

Primary Care Physician: _____ **Phone Number:** _____

Referring Provider: _____ **Phone Number:** _____

How did you hear about us? _____

Employer: _____**Occupation:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____

Preferred Pharmacy: _____ **Address:** _____ **Phone**: _____

☐ Check if Self and skip this section

Financially Responsible Party Name: _____ **Date of Birth:** _____/_____/_____

Sex: Male ☐ Female ☐ **Address** :_____

City, State: _____**Zip Code**: _____**Home/Cell Phone**:_____

PRIMARY INSURANCE

Primary Insurance Company: _____**Policy Holder Name:** _____

Policy Holder Date Of Birth: _____/_____/_____ **Policy Holder Employer:** _____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy ID # : _____ **Group Number:** _____

SECONDARY INSURANCE

Secondary Insurance Company: _____**Policy Holder Name:** _____

Policy Holder Date Of Birth: _____/_____/_____ **Policy Holder Employer:** _____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy ID # : _____ **Group Number:** _____

Patient Signature: _____ **Date:** _____

PLATTSBURGH ENT

Plattsburgh Otolaryngology–Head and Neck Surgery, PLLC
79 Hammond Lane Suite 12 • Plattsburgh, NY 12901
Phone: 518-566-7930 • Fax: 518-566-7932