



Account # _____
(for office use only)

ADULT REGISTRATION FORM

Today's Date _____ Referred by: _____ Primary Care Dr: _____

Last Name: _____ First: _____ Middle: _____ Nickname: _____

Date of Birth: _____ Sex: Male Female Other Social Security #: _____
Preferred

Pharmacy: _____ City: _____ Primary Language: English Other: _____

Marital Status: Single Married Widowed Divorced Other _____ Religion: _____

Race: White Black Asian Other Declined Ethnicity: Hispanic/Latino Not Hispanic Other Declined

Address: _____ Address 2: _____
If address is PO Box mailing address, include street address in Address 2

City: _____ State: _____ Zip _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____ Preferred phone Hm Wk Cell

(Optional) Preferred Method of
Email: _____ @ _____ Communication: Phone Mail E-Mail Text Portal (Avail. Oct 2011)

Employer: _____ Address: _____

Spouse's Name: _____ Address: Same Other: _____

Spouse Employer: _____ Work Tel: _____ Cell #: _____

INSURANCE SUBSCRIBER INFORMATION:

1) Primary Insurance: _____	2) Secondary Insurance: _____
ID#: _____	ID#: _____
Group Name or # _____	Group Name or # _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder DOB: _____	Policy Holder DOB: _____
Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____
Policy Holder SSN #: _____	Policy Holder SSN #: _____

In case of emergency, contact: _____ Relationship: _____
Home phone: _____ Work # _____ Other: _____

Workman's Comp. or Accident Information: Please advise the receptionist if you are here as a result of a work or accident related injury so we may obtain additional information. Date of Accident: _____

Medical or billing information and appointment reminders may be discussed with: No one Spouse Other: _____
I give permission for Concord Otolaryngology/Alliance Audiology to leave a message or appointment reminder at the following numbers: Home Cell Phone Employer Other: _____

RELEASE OF INFORMATION: I hereby authorize Concord Otolaryngology to release my medical records to any appropriate doctor, hospital, or health agency. I authorize the physicians to administer my treatment or perform procedures deemed necessary in the diagnosis and treatment of my condition. I authorize taking of photographs for medical purposes if necessary.

Patient or Guardian Signature: _____ Relationship to patient _____