



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 \_\_\_\_\_