PugetSoundENT

REGISTRATION FORM

NEW_____ UPDATE_____

GENERAL INFORMATION

PATIENT LAST NAME		FIRST NAME (legal)	MI	PREFERRED OR NICKNAME
DATE OF BIRTH	SEX M F	RACE ETHNICITY	SOCIAL SECURITY # PREFERRED LANGUAGE	

MAILING ADDRESS	APT#	CITY	STATE	ZIP CODE 4 DIGIT
STREET ADDRESS	APT#	CITY	STATE	ZIP CODE 4 DIGIT

HOME PHONE	WORK PHONE EXT	CELL PHONE

REFERRING DOCTOR	MARITAL STATUS
PRIMARY CARE DOCTOR	MARRIED _____ DIVORCED _____ SINGLE _____ WIDOWED _____ SEPARATED _____
PREFERRED EMAIL ADDRESS	

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOUR RETIRED ____ OR DISABLED ____)

EMPLOYER NAME		OCCUPATION	
STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT

PRIMARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME		SUBSCRIBER'S EMPLOYER	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE _____ FEMALE _____	SUBSCRIBER'S ID #	GROUP NUMBER

SECONDARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER	COPAY
SUBSCRIBER'S NAME		SUBSCRIBER'S EMPLOYER	
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE _____ FEMALE _____	SUBSCRIBER'S ID #	GROUP NUMBER

RESPONSIBLE PARTY

WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

. SELF (*IF SELF DO NOT FILL IN RIGHT FIELD) _____ SPOUSE _____ PARENT _____ GUARDIAN	SOCIAL SECURITY #	LAST NAME	FIRST NAME	MI
	STREET ADDRESS	CITY	STATE	ZIP CODE 4 DIGIT
	HOME PHONE	WORK OR CELL PHONE EXT	DATE OF BIRTH	SEX M F

WORKER'S COMP CLAIM #	DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED?

RELEASE OF BENEFIT AND INFORMATION

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PROLIANCE SURGEONS, INC. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE, *INCLUDING MONTHLY SERVICE CHARGES ON PATIENT BALANCES OVER 60 DAYS.*
I AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM.

PATIENT SIGNATURE _____ DATE _____