TEXAN ENT Specialists

PATIENT REGISTRATION			
Patient Name: (Last, First, Middle)			Social Security Number
Cell Phone:	Home Phone:	Work Phone:	Email address:
Address:	City:	State:	Zip:
Date of Birth:	Age:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Sex: ☐ M ☐ F
Place of Employment/School Name:	**Race:** Caucasian / Hispanic or Latino / African American / Other:_____ **Ethnicity:** Hispanic or Latino / Non-Hispanic or Latino / other		
Parent/Legal Guardian (if minor):	Relationship to Patient:		
Address/City, State, Zip (if different from above):			Phone#:
Emergency Contact:	Relationship to Patient:		Phone:
REASON FOR VISIT:			Date of Onset:
Name and number of Referring Doctor:	Name and number of Primary Care Doctor:		

HEALTH INSURANCE INFORMATION			
PRIMARY INSURANCE NAME:	ID#:	Group#:	Phone#:
Policy Holder/Employees Name:	DOB:	SSN:	Relationship to insured: ☐ Self ☐ Spouse ☐Child
SECONDARY INSURANCE NAME:	ID#:	Group#:	Phone#:
Policy Holder/Employees Name:	DOB:	SSN:	Relationship to insured: ☐ Self ☐ Spouse ☐Child

Referral Information

Dr. Referral Family/Friend:_____ Google Insurance Website Radio Insurance Carrier Other:_____

How would you like to be contacted? Email Phone Text Mail (please circle one or more)

_____ _____

Patient Signature (If patient is a minor/Parent or Guardian Signature) Date