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: _____________ Street: ______________ 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) Email: ___________________@__________________ Preferred Method of Communication: ☐Phone ☐Mail ☐E-Mail ☐Text ☐Portal

Employer: ____Address: ____

Spouse's Name: ___________________________________ Address: ☐Same ☐Other: __________________________________

Spouse Employer: ___________________________________ Work Tel: ____________________ Cell #:____________________

INSURANCE SUBSCRIBER INFORMATION:

1) Primary Insurance:________________________________
ID#: ____
Group Name or #_________________________________
Policy Holder Name:______________________________
Policy Holder DOB:__________________________
Relationship to patient: ☐Parent ☐Spouse ☐Other_________
Policy Holder SSN #:________________________

2) Secondary Insurance:_________________________________
ID#: ____
Group Name or # ____________________________________
Policy Holder Name:__________________________________
Policy Holder DOB:_____________________________
Relationship to patient: ☐Parent ☐Spouse ☐Other__________
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/Alliance Audiology 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