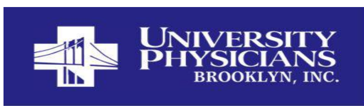

University Physicians of Brooklyn
Department of Otolaryngology

OTOLARYNGOLOGY PRACTICE
New Patient Registration Record
Please Print

PATIENT NAME____
LAST FIRST MIDDLE ☐ MALE ☐ FEMALE

HOME ADDRESS____________________________Apt_________City___________________ State______ Zip________

HOME PHONE ( )______________________CELL/BEEPER ( )______________________Work ( )______________

PATIENT'S SS#_____________________________________ PATIENT'S DATE OF BIRTH_________________________

INSURED'S SS#_____________________________________ INSURED DATE OF BIRTH__________________________

IF PATIENT IS A CHILD; PLEASE INDICATE PARENT/GUARDIAN'S NAME(S):

MOTHER/PARENT:_____________________________( ) _____________________ ( )_______________________
DAY PHONE CELL/BEEPER

FATHER/PARENT:_____________________________( )_________________________( )_____________________

MOTHER/PARENT EMAIL ADDRESS:____

MOTHER/PARENT EMAIL ADDRESS:____

RESPONSIBLE PARTY FOR PAYMENT:____

EMPLOYER:____ TEL # ( )___________________________________

EMPLOYER ADDRESS___________________________________ City___________________ State________ Zip________

PRIMARY INSURANCE____ POLICY # ____________________________

SECONDARY INSURANCE____ POLICY # ____________________________

My signature below indicates that I am requesting care in this office and consent to medical treatment. I authorize Dr. __________________ to release medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I have insurance coverage with the above named company and assign directly to the physician all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient or Responsible Party Signature____ Date:_____________________

In case of emergency whom should we contact?
Name____ Relation to Patient_____________________________

Address____ City_____________________ State _______ Zip________

DAY PHONE ( )________________________________ EVE/CELL/BEEPER ( )____________________________

☐ **LOCAL PHARMACY:**

Name: ____

Address: ____ Phone #__________________________________

How did you find out about our practice?

☐ Word of Mouth (friend, relative, colleague) ☐ Advertisement (Yellow Pages, etc.)

☐ Referred by other MD___________________________ Address:____

☐ Insurance or Managed Care Program ☐ Other____

PRIMARY (PCP) DOCTOR ____PHONE ( )_______________________________

ADDRESS ____ City__________________ State________ Zip____________

* PLEASE HAND IN THE FOLLOWING WITH THIS SHEET:
REFERRAL FORMS, INSURANCE FORMS, and INSURANCE CARD
THANK YOU!