Puget Sound Ear Nose & Throat

A Member of Proliance Surgeons, Inc., P.S.

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
	MARRIED _____ DIVORCED _____
PRIMARY CARE DOCTOR	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 _____