OKLAHOMA OTOLARYNGOLOGY ASSOCIATES, L.L.C.

Patient Registration Form

OKLAHOMA HEARING CENTER

Patient Information:					
Patient Name, Last	First:		MI:	Acct #:	
Mailing Address:	City, State, Zip:		Home Phone: Cell Phone:		
D.O.B. SS#:	Marital Status:	Sex: (M/F)	Referring Physician:		
Employer: Employer Phone#:	**Meaningful Use Verification:** Preferred Language**:** _____ **Race:** ☐White ☐American Indian/Alaskan Native ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Hispanic/Latino ☐ Asian ☐Other Race				
Email Address:					

Responsible Party: (If other than above, when patient is under 18 years old) **{Please note – Anyone over the age of 18 years old is financially responsible for their own statements}**		
Name:	Employer:	D.O.B:
Mailing Address:	City, State, Zip:	Phone: SS#:
Relationship to Patient: PARENT STEP PARENT GRANDPARENT FOSTER PARENT {please circle one} OTHER:		

Primary Insurance:	
Name & Phone Number of Insurance:	Insurance ID Number:
Insurance Address:	Group #:

Insurance Subscriber Information:			
Name (Last, First, MI)	Relationship to Patient:	Phone #:	
Subscriber SS#:	Sex (M/F)	D.O.B:	Employer:
Subscriber Address:			

Secondary Insurance:	
Name & Phone Number Of Insurance:	Insurance ID Number:
Insurance Address:	Group #:

Insurance Subscriber Information:			
Name (Last, First, MI):	Relationship to Patient:	Phone #:	
Subscriber SS#:	Sex (M/F)	D.O.B:	Employer:
Subscriber Address:			

Emergency Contact: NOT AT THE SAME ADDRESS AS PATIENT		
Name:	Phone #:	Relationship:
Address:	City, State, Zip	
Are you being seen today for a work or auto related accident? YES or NO		

All charges are due at the time of service. All services rendered are charged to the patient or their responsible party. I understand that I am responsible for any amount not covered by my insurance. Therefore, I hereby authorize the doctors of Oklahoma Otolaryngology Associates to furnish information to insurance carriers concerning my illness and treatment. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. I assign to the physician(s) all payments for medical services rendered to myself.

Signature: _____ Date: _____