EASTERN OKLAHOMA
EAR, NOSE & THROAT, Inc.

PATIENT REGISTRATION FORM

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

SSN#: _____ Date of Birth: _____ Age: _____ Sex: ☐ Female ☐ Male

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Day Phone: _____ Cell Phone: _____

Alternate Contact Name: _____ Phone: _____ Relationship: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of Primary Care Physician /Pediatrician (first and last name): _____

Referring Physician Name (first and last name, if different): _____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other: _____

Language: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic E-mail Address: _____

Responsible Party (list both parents/guardians if the patient is a child)

Name: _____

Relationship: _____

Birthdate: _____ SSN#: _____

Address: _____

City/State/Zip: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Employer: _____

Name: _____

Relationship: _____

Birthdate: _____ SSN#: _____

Address: _____

City/State/Zip: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Employer: _____

Primary Insurance: _____

Insurance Company: _____

Policy Holder: _____

Policy Holder DOB: _____

I.D.#: _____ Group: _____

Employer: _____

Secondary Insurance: _____

Insurance Company: _____

Policy Holder: _____

Policy Holder DOB: _____

I.D.#: _____ Group: _____

Employer: _____

I hereby assign to Eastern Oklahoma Ear, Nose & Throat, Inc., any and all rights and interest in insurance benefits and direct that all such payments be made directly to the clinic. I understand that I am financially responsible for all deductibles, coinsurance and all services not covered by insurance benefits and/or entitlements.

Eastern Oklahoma Ear, Nose & Throat, Inc. physicians have a financial interest in Tulsa Spine & Specialty Hospital, LLC (TSSH). Your physician may refer you to the TSSH facility, where medical procedures may be performed. The Oklahoma Financial Disclosure Statute requires that we inform you of your physician's financial interest in Tulsa Spine & Specialty. I acknowledge the disclosure and authorize any holder of information about me to release to the health plan indicated and the information needed to determine these benefits payable to related services.

Signature: _____ Date: _____

Yale Office - 5020 E 68th Street, Tulsa, OK 74136
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