ALEXIOU HEARING & SINUS CENTER
PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name		Date of Birth	Sex	Age
Nickname or Preferred Name:				
Parent if Patient is a Minor		Social Security Number		Date of Birth
Patient's Social Security Number		Driver's License No.		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number		Work Telephone Number		Cell Phone #
Occupation		Employer's Name or if Student, Name of School:		
Employer's Address	City	State	Zip	
Spouse's Name		Employer		
Patient's Family Physician (Doctor's Name not Group)				
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
FINANCIAL INFORMATION: MEDICAL INSURANCE POLICY HOLDER'S (SUBSCRIBER'S) NAME				
Name		Telephone	Relationship to patient	
Address	City	State	Zip	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
DO WE HAVE YOUR PERMISSION TO:				
Leave a message on your answering machine at home?			☐ Yes	☐ No
Leave a message at your place of employment?			☐ Yes	☐ No
Discuss your medical condition with any member of your family?			☐ Yes	☐ No
If yes, with whom:		Relationship:		

Please Read Our Financial Policy Statement and Agreement on Reverse