Ear, Nose & Throat
Physicians & Surgeons, P.A.

Jeffrey Byer, M.D.
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PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: _____ Sex: _____
Mailing Address: _____ City: _____ St: _____ Zip: _____
Phys Address: _____
Email: _____ SS#: _____
Home Phone: _____ Cellphone: _____ Work Phone: _____
May we leave messages on all numbers? ☐ Y ☐ N
Marital Status: _____
Employed: ☐ Full time ☐ Part time ☐ Retired ☐ Student ☐ Not Emp
Preferred Language: _____ Ethnicity: _____ Race: _____

I have authorized ENT Physicians & Surgeons to speak to the following on my behalf:

_____

PRIMARY CARE PHYSICIAN

Primary Care Physician: _____ Phone: _____
Address: _____ City: _____ St: _____ Zip: _____

Referring Physician (if different)

Referring Dr: _____ Phone: _____
Address: _____ City: _____ St: _____ Zip: _____

Responsible Party's Information (if patient is under the age of 18 or payer is different)

Guarantor: _____ DOB: _____ Sex: _____
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Cellphone: _____ Work Phone: _____

MEDICAL INSURANCE INFORMATION

☐ Insurance Card Scanned

Primary Insurance: _____ Ins Phone: _____
Address: _____ City: _____ St: _____ Zip: _____
Cert No: _____ Group No: _____
Subscriber: _____ DOB: _____

Secondary Insurance: _____ Ins Phone: _____
Address: _____ City: _____ St: _____ Zip: _____
Cert No: _____
Subscriber: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ DOB: _____
Home Phone: _____ Cellphone: _____

I understand that my signature authorizes payment by my insurance carrier to the provider and authorize the release of all medical information necessary to pay insurance claims. I authorize the release of all medical information necessary for continuity of patient care. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collections monies owed, including court costs and attorney fees.

_____ _____
Signature (patient or Legal Guardian) Date