Dr. Malis
FAMILY ENT & AUDIOLOGY

New Patient Registration

Patient:

Last Name:_____ First Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: ( )_____ Date of Birth:_____

Email: _____

Sex: M / F Social Security:_____

Employed/School Grade:_____ School Name:_____

Referring Physician:_____Physician Phone: ( )_____

Employer:

Address:_____ City:_____

State:_____ Zip Code:_____ Phone: ( )_____

INSURANCE INFORMATION

Primary Insurance:_____ Phone: ( )_____

Ins #:_____ Group #:_____

Effective Date:_____ Member #:_____

RESPONSIBLE PARTY INFORMATION
(Person insurance is under)

Last Name:_____ Initial:_____ First:_____

Date of Birth:_____ Sex: M / F Social Security:_____

Address:_____ City:_____

State:_____ Zip Code:_____ Phone: ( )_____

Employer: Address:_____ City:_____

State:_____ Zip Code:_____ Phone: ( )_____

Nearest living relative or friend not living with you _____
Relative/friend _____ Phone:( )_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Signature:_____ Date:_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature:_____ Date:_____