

PATIENT REGISTRATION

Rancho Ear, Nose & Throat

Ashish K. Wadhwa, M.D.

PERSONAL

Name _____ Date of Birth ____/____/____ Age ____ M F

Address _____

City _____ State ____ Zip _____ Social Security # _____

Phone _____ Cell _____ Fax _____ Email _____

EMPLOYMENT

Employer _____ Work Phone () _____

Address _____ Occupation _____

City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____ Relationship _____ Home Phone () _____

Address _____ Business Phone () _____

Employer _____ DOB ____/____/____ Social Security # _____

IN CASE OF EMERGENCY (Please provide the name of an additional contact person.)

Name _____ Relationship _____

Address _____ Phone () _____

INSURANCE (Please present cards to receptionist-you can skip this if we have a copy of your cards.)

PPO Medicare HMO Cash Other _____

Primary Insurance Name _____ Subscriber _____

Secondary Insurance Name _____ Subscriber _____

REFERRAL

Who referred you to our office? _____

Yellow Pages Insurance Book Physician Friend Palomar/Pomeroado Hospital

Which search engine or phone book did you use to find us? _____

I give my permission for treatment by Dr. Wadhwa, and I give my permission to Rancho Ear, Nose & Throat to release information to my insurance carrier. I authorize my insurance carriers to pay benefits directly to Rancho Ear, Nose & Throat.

Signed _____ Date _____