

McCOOL & BHUTA

Ear Nose and Throat Specialists

NEW PATIENT REGISTRATION

Name: _____

Address: _____

City, State, Zip: _____

Phone Home: _____ Cell: _____ Office: _____

DOB: _____ Sex: _____ Email: _____

SS#: _____ Employer: _____

Referring Doctor: _____ Phone: _____

Please sign here if we may send communications to you via email:

We use electronic Rx transmissions; please provide the pharmacies that you use.

Pharmacy Name & Telephone: _____

Insurance cards and driver's license will be scanned by receptionist.

IF MEDICARE IS SECONDARY PLEASE INDICATE WHY: ex: (on disability, etc)

If insurance is in someone else's name other than patient please fill out below:

Name of Subscriber: _____

DOB: _____ Relationship: _____

Minor Patient Please fill out (Patient under 18 years of age)

Parents: _____

Address: _____

Phone: Home: _____ Cell: _____ Office: _____