

OTOLARYNGOLOGY - HEAD & NECK SURGERY
New Patient Registration

Please print out this form, fill it out, and mail (or fax) it to the address below.

Stanford University
Department of Otolaryngology - Head & Neck Surgery
801 Welch Road
Stanford, CA 94305
Voice: (650) 723-5281
Fax: (650) 725-6685

Confidentiality Notice: this form may contain confidential medical information. The information in this form is confidential and privileged. It is unlawful for an unauthorized person to review, copy, disclose or disseminate confidential information. If the reader of this warning is not the intended recipient or agent, you are hereby notified that you have received this form in error and that review or further disclosure of the information contained therein is strictly PROHIBITED. If you have received this form in error, please notify us immediately at the telephone number indicated above and return the original message to us by mail. Thank you.

Patient Name: _____
Date of Birth: ____/____/____
Male or Female: _____
Address Line 1: _____
Address Line2: _____
City: _____
State: _____ Zip Code: _____
Race: _____ Marital Status: _____
Language Needed: _____
Social Security Number: ____-____-____
Stanford Medical Record Number (if known): _____
Home Telephone: (____)_____
Work Telephone: (____)_____
Cellular Telephone: (____)_____
FAX: (____)_____

Primary Insurance Provider: _____
Patient Group #: _____
Patient Subscriber ID: _____
Type of Ins. (HMO, PPO, EPO, POS, MediCare, MediCal) _____
Telephone Number for Eligibility: (____)_____
Subscriber Name: _____

Work Status (Full-Time, Part-Time, Retired, Student): _____
Occupation: _____
Employer Name: _____
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Zip: _____
Telephone: (_____)_____

Emergency Contact :
Contact Name: _____
Pt. Relationship to Contact: _____
Address: _____
City/State: _____
Zip Code: _____
Tel: _____
Work: _____
Alt: _____
Alt Phone Type: _____

Referring Doctor: _____
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Zip: _____
Telephone: (_____)_____
FAX: (_____)_____

Primary Care Doctor: _____
Address Line 1: _____
Address Line 2: _____
City: _____ State: _____ Zip: _____
Telephone: (_____)_____
FAX: (_____)_____

Reason for Visit: _____

Desired Appointment Dates and Times:
1) _____
2) _____
3) _____

Insurance Authorization Number (if applicable) _____