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

First Name: _____
Middle Initial: ___
Last Name: _____
Date of Birth: _____
Gender: _____
Patient Address: _____
_____
City: _____
State: _____ Zip Code: _____
Race: _____ Marital Status: _____
Language: _____
Social Security Number: _____ - ____ - _____
Stanford Medical Record Number (if known): _____
Home Telephone: (_____) _____
Work Telephone: (_____) _____
Cell Telephone: (_____) _____
FAX: (_____)

Employment Status: _____

Occupation: _____
Industry: _____
Company Name: _____
Company Address: _____

_____

Insurance Provider:_____
Patient Group Number: _____
Policy Number: _____
Patient Subscriber ID: _____
Type of Insurance (HMO, PPO, EPO, POS, MediCare, MediCal): _____
Insurance Telephone: (_____) _____
Subscriber Name:_____

Emergency Contact :
Contact Name: _____
Relationship: _____
Contact Telephone: (_____) _____

Referring Doctor:_____
Doctor Address: _____
_____
Telephone: (_____)
FAX: (_____)_____

Primary Care Physician: _____
Physician Address: _____
_____
Physician Telephone: (_____)_____
FAX: (_____)_____

Allergies: _____

_____

Reason for Visit: _____

_____

_____

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

Insurance Authorization Number (if applicable)_____