

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.

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) _____