BEACHES EAR, NOSE AND THROAT, P.A.
Jeffrey E. Brink, M.D., F.A.C.S.
Patient Registration

Date:_____ Referring Doctor:_____
Primary Care Doctor: _____

PATIENT DEMOGRAPHICS

Last Name:_____ First:_____ M.I.:_____

Male/Female:____ Marital Status:_____ Social Security#:_____ DOB:_____

**Race (please circle): *Asian, American Indian, Black, White, Other* Language: _____

**Ethnicity (please circle): *Hispanic, NOT Hispanic, Not Provided/Refuse to Report*

Email Address:_____

Home/Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell#:_____ Work#:_____

Preferred Contact Method: (ex: cell phone, home phone): _____

Employer:_____

Emergency Contact:

Name:_____ Phone#:_____ Relationship:_____

Responsible party if different than patient (Children under 18):

Last Name:_____ First Name:_____ DOB:_____

Relationship:_____

Insurance: Please present insurance card and photo ID to receptionist

Insurance Name:_____ ID#:_____

Policy Holder's Name:_____ DOB:_____

Social Security#:_____ Relationship to policy holder: _____

Do you have other insurance? Yes:_____ No:_____

Insurance Name:_____ ID#:_____

Policy Holder's Name:_____ DOB:_____

Social Security#:_____ Relationship to policy holder: _____

Release of Information

I, the undersigned, authorize Beaches Ear, Nose and Throat, PA, to speak with the persons listed below regarding my medical care. I understand that with my signature I am authorizing the release of written and/or oral communication by Beaches Ear, Nose and Throat, PA to the listed persons and thereby release Beaches Ear, Nose and Throat, PA and their staff from all legal responsibility that may arise from the act hereby authorized.

Is it okay to leave voicemail with results?:_____

Authorized Person:_____ Relationship to patient:_____ Phone#_____

Authorized Person:_____ Relationship to patient:_____ Phone#_____

Signature of patient or responsible party:_____ Date:_____