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

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. Relatationship 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)_____