**CMH Physician Services, LLC – Ear, Nose & Throat**
A Service of VCU Community Memorial Hospital

**Patient Registration** (PLEASE PRINT CLEARLY)

**Patient's Name**: _____ **Social Sec. #:** _____

**Date of Birth**: _____ Primary Phone #: _____ Secondary Phone #: _____
Home Cell Business Home Cell Business

Male ____ Female ____ Single ___ Married ___ Widowed ___ Divorced ___ Separated ___

Email Address: (print clearly) _____

**Preferred Method of Communication:** Home Ph. ___ Cell Ph. ___ Work Ph. ___ Email. ____

Ethnicity: _____ **Primary Language:** English____ Spanish____ Other____

**Mailing Address**: _____ City, State: _____ Zip_____

Patient's Employer: _____ Work Phone #: _____

**Preferred Pharmacy:** _____ City, State: _____

Family Doctor: _____ City, State: _____

Spouse's Name: _____ Social Sec. #: _____

Spouse's Date of Birth (If he/she is the primary insurance holder): _____

**Responsible Party:** _____ Relationship to Patient: _____

Emergency Contact Name: _____ Ph. # w/ Area Code: _____

Relationship to Patient: _____ DOB: _____

If patient is a Minor, are parents ___ Married ___ Divorced - Custodial Parent: _____

Custodial Parent Home Ph. w/Area Code: _____ Work Ph. w/Area Code _____

Custodial Parent SS #: _____ Date of Birth: _____

Is this a work-related visit? ___ Yes* ___ No If yes, date of injury? _____ Claim #: _____

*If this is a work related visit you will be required to complete Workers' Compensation/Insurance Form

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# MUST PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING

**If you do not have insurance, how do you plan to pay for your visit today?** ___ Cash ___ Credit ___ Check

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- I hereby authorize the payment of medical benefits to CMH Physician Services, LLC – ENT for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collection costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize CMHPS Ear, Nose & Throat to release any medical information necessary to complete and process my insurance claims.

_____ _____

Patient's or Insured's **Signature** (If pt is a Minor, must have Responsible Party Signature) **Date**