THE EAR, NOSE AND THROAT CLINIC
& HEARING CENTER

RENEW
FACIAL PLASTIC SURGERY

Patient Registration

Patient Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Sex: M F

Address: _____ Apt/Unit: _____

City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Referral Source: _____

Employer/Occupation: _____

If patient is a minor:

Parent/Guardian Name: _____

Date of Birth: _____ Sex: M F

☐ Check if address is same as patient. If not, please provide below

Address: _____ Apt/Unit: _____

City/State/Zip Code: _____

Insurance Information

Primary Insurance Company: _____

Policy Holder: _____ DOB: _____

Secondary Insurance Company: _____

Policy Holder: _____ DOB: _____

I have verified that the information above is correct.

Patient Name: _____

Signature: _____ Date: _____