□ Michael J. Rooney, M.D.
□ George D. Lyle, M.D.
□ C. Ron Brooker, M.D.
□ Robert M. Merritt, M.D.
□ Joseph J. Bradfield, M.D.
□ Elizabeth P. Sundean M.D.
□ Mike M. Stuart, M.D.

THE BARRANCO CLINIC
Otolaryngology-Head & Neck Surgery
Allergy • Facial Plastic & Reconstructive Surgery

Acct # _____ Pt. #_____

Financial Class _____

Today's Date _____By:_____

PATIENT REGISTRATION

Patient's Name: _____ Age: _____ Sex: ☐ Male ☐ Female

Birth Date: _____ Home Phone #: _____S.S. #: _____

Cell #: _____Work #:_____Email: _____

Mailing Address: _____

Street Address: (if different)_____ City/State: _____ Zip: _____

Out of State Address: _____ City/State: _____ Zip: _____

Name of Person Responsible for Account: _____

Address: _____

Name of Spouse: _____ D.O.B.: _____ S.S.#: _____

Name of Father (if minor): _____ D.O.B.: _____ S.S.#: _____

Name of Mother (if minor): _____ D.O.B.: _____ S.S.#: _____

Name of Legal Guardian (if minor) _____ D.O.B.: _____ S.S.#: _____

Patient Employed by: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

Husband/Father Employed by: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

Wife/Mother Employed by: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

Referring Physician: _____ Physician's Phone: _____

Referring Physician's Address: _____

PCP Physician, if different from referring physician:_____Phone:_____Fax:_____

Primary Insurance: _____

Address of Company: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Effective Date: _____

Secondary Insurance: _____

Address of Company: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Effective Date: _____

Local Pharmacy: _____Phone #:_____

Address of Pharmacy: _____City_____ST_____Zip_____

rev 05/13

PAYMENT IS EXPECTED AT THE TIME PROFESSIONAL SERVICES ARE RENDERED.