# Patient Registration Form

**Ear, Nose, and Throat Associates**
**Watauga Hearing**

**Patient** ______________________________________________ **SSN#**____________________
. First Name Middle Initial Last Name

**Preferred Name**______________________ **Email Address**______________________________

**Mailing Address** ____________________________________________________________
Number & Street, Apt, Unit, etc. City State Zip Code

**Date of Birth** ________________ **Age** ________ **Sex** _________ **Marital Status** ________________

**Race (please circle):** Hispanic, Asian, Caucasian - White, African American, Native American Indian, Other, Decline

**Ethnicity (please circle):** Hispanic or Latino, Non-Hispanic or Latino, Other, Decline **Preferred Language**________________

**Patient's Home Phone #** ______________ **Cell Phone #**________________ **Work Phone #**______________

**Employer**____________________ **Employer Address or Location**_________________________

**Preferred Method of Contacting You (please circle all that apply):** Letter, Home Phone, Email, Text-SMS, Cell Phone, Work Phone

**Emergency Contact Name** ____________________ **Relationship** ________ **Phone #** ______________

**What doctor referred you to us** ______________________________________________
First Name Last Name Practice Name & City, State

**Who is your Primary Care Doctor** ______________________________________________
First Name Last Name Practice Name & City, State