BECHARA Y. GHORAYEB, MD, PA
OTOLARYNGOLOGY- HEAD & NECK SURGERY
8830 LONG POINT, SUITE 806
HOUSTON, TX 77055

PHONE: 713 464 2614
FAX: 713 464 0729

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	**Social Security Number:**	**Home phone number:** ( )
City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )

Who referred you to our office?	❑ Dr.	❑ Internet	❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

e-mail: **Other phone / Cell phone:** ( )

INSURANCE INFORMATION

(Please give your insurance card and a picture ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company (ies). The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Bechara Y. Ghorayeb, MD, PA.

I understand that I am financially responsible for all charges, whether or not paid by insurance. I also authorize Bechara Y. Ghorayeb, MD, PA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and authorize the insurance company to release any information required to process my claims.

Patient/Guardian signature: Date: