Heidi Heras, MD

ears, nose & throat specialist

PATIENT REGISTARTION/UPDATE FORM
PATIENT INFORMATION

EARS • NOSE • THROAT • WWW.DRHEIDIHERAS.COM

Patient Legal Name: ______________________ DOB ____________

Preferred Name ______________________ ❑ Male ❑ Female

HEALTH INSURANCE INFORMATION (Required)

Primary Insurance (write above the lines)

Name of insurance plan

Insurance ID number

Name of policy holder

Policy holder's date of birth

Employer or Group Number

Secondary Insurance (write above the lines)

Name of insurance plan

Insurance ID number

Name of policy holder

Policy holder's date of birth

Employer or Group Number

PATIENT/PARENT/GUARDIAN INFORMATION

Parent/Guardian

Full Name (write above the lines)

DOB:

Home Address:

City: ____________ State ______ Zip ______

Phone Numbers

Home: ____________

Cell: ____________

Email: ____________

Insured

Full Name (write above the lines)

DOB:

Home Address:

City: ____________ State ______ Zip ______

Phone Numbers

Home: ____________

Cell: ____________

Email: ____________

→ ❑ **Yes, I have read, understand and agree to the provisions of the financial policy. I further understand that Dr. Heras reserves the right to alter this policy at any time.**

For office use only:

__/__/__ __/__/__ __/__/__

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