ent specialists pc℠

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____Sex: _____
(Last) (First) (MI)

Patient's Social Security Number: _____-_____-_____ Home Phone:_____

Address: _____ Work Phone: _____

City: _____ State:_____ Zip_____ Cell Phone: _____

Patient's Employer: _____ Email: _____

Marital Status (Circle): Single Married Other: _____

Usual ENT Provider (Circle One): Denman Farrell Goebel Quinlan Sewell Sully

Referring Doctor _____Primary Care Physician_____

ACCOUNT INFORMATION

Emergency Contact**:** _____ Phone: _____
(Name) (Relationship)

Minor Patients:

Mother's Name _____ Home Phone:_____

Address _____ Cell Phone:_____
(if different from above)

Mother's Employer: _____ Work Phone:_____

Father's Name _____ Home Phone:_____

Address_____ Cell Phone: _____
(if different from above)

Father's Employer: _____ Work Phone: _____

Who is the guarantor on the patient's account (person responsible for payment)? _____

POLICY HOLDER INFORMATION/GUARANTOR INFORMATION:

(Primary Policy)

*Primary Insurance Company:_____*Patient Relationship to Card Holder (Circle below):

*Primary Card Holder's Name: _____ Self Spouse Child Other:_____

*Social Security Number: _____ - _____ - _____ *Card Holder's Birth Date: _____

*Card Holder's address if different than patient's:_____

(Secondary Policy—not all patients will have a secondary)

***Secondary Insurance Company: _____ *Patient Relationship to Card Holder (Circle below):

*Secondary Card Holder's Name: _____ Self Spouse Child Other:_____

*Social Security Number: _____ - _____ - _____ *Card Holder's Birth Date: _____

*Secondary Card Holder's address if different than patient's: _____

ADDITIONAL INFORMATION

Race (Circle One): ☐ White ☐ Black ☐ Native American ☐ Asian/Pacific Islander ☐ Other ☐ Prefer not to answer

Ethnicity (Circle One): ☐ Hispanic ☐ African American ☐ Caucasian ☐ Other ☐ Prefer not to answer

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Pharmacy: _____ Pharmacy Address: _____