Community Ear Nose Throat & Allergy

Confidential Patient Information

PATIENT INFORMATION

Last Name:______________________ First:______________________ MI ________

Birthdate:______________________ SSN:______________________ Sex: M / F

Address:______________________

City:______________________ State:____________ Zip:______________________

Phone: (Home)______________________ (Work)______________________ (Cell)______________________

Email: ______________________ Employer:______________________

Marital Status:__________ Spouse Name:______________________

Referring Physician:______________________ Phone #______________________

Primary Care:______________________ Phone #______________________

PARENT'S/GUARDIAN INFORMATION (*Complete Only If Patient Is A Child*)

Mother's Name:______________________ SSN______________________ Birthdate______________________

Mother's Phone: (Home)______________________ (Work)______________________(Cell)______________________

Father's Name:______________________ SSN______________________ Birthdate______________________

Father's Phone: (Home)______________________ (Work)______________________(Cell)______________________

Legal Guardian Name:______________________ SSN______________________ Birthdate______________________

Guardian's Phone: (Home)______________________ (Work)______________________(Cell)______________________

Who Does Child Reside With? ______________________

INSURANCE INFORMATION (*Must Complete & Must Have Copy of Card*)

Primary Insurance:______________________ Policy ID#:______________________

Policy Holder's Name:______________________ Birthdate:______________________ SSN:______________________

Relationship to Patient (Circle One) SELF SPOUSE CHILD OTHER______________________

Secondary Insurance:______________________ Policy ID#:______________________

Policy Holder's Name:______________________ Birthdate:______________________ SSN:______________________

Relationship to Patient (Circle One) SELF SPOUS E CHILD OTHER______________________

EMERGENCY CONTACT

Name of Relative or Friend:______________________

Phone: (Home)______________________ (Work)______________________ (Cell)______________________

I give my consent to the physicians at Community ENT & Allergy to examine & render treatment as appropriate for the above named patient.
I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all/any balance. I authorize Community ENT & Allergy, PLLC or insurance company to release any information required to process my claims.

______________________ ______________________

Signature of Patient/Parent/Guardian Date Signed