ENT Associates

Making sense of your family's hearing, sinus and throat problems

# PATIENT INFORMATION (*Please print clearly)*

**Patient Demographics:** Date: _____

Last Name: _____ First: _____ MI: _____ Suffix: _____

Date of Birth: _____ Sex: M / F Social Security #: _____

***(Please check one):***

**Race:** □ American-Indian □ Asian □ Black/African American □ White □ Other □ Declined

**Ethnicity:** □ Hispanic/Latino □ Other □ Declined

Primary Language: _____ Marital Status: _____

**Address:** _____Apt/Lot #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Primary Number: □ Home □Work □ Cell

E-mail address: _____ Patient's Employer: _____

Preferred Communication: *(Please check one)* □ Home # □ Cell # □ Work # □ Email □ Patient Portal □ Text

**Primary Insurance:** _____

Policy #: _____ Group #: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to Patient: _____

Policy Holder SSN: _____ Employer: _____

**Secondary Insurance:** _____

Policy #: _____ Group #: _____

Policy Holder Name: _____

Policy Holder DOB: _____ Relationship to Patient: _____

Policy Holder SSN: _____ Employer: _____

**Primary Care Physician:** _____ **Referring Provider:** _____

**Pharmacy Name:** _____ Phone #: _____

Pharmacy Location: _____

****** Do you live at another address for any part of the year? ☐ Yes or ☐ No ******

If the answer is yes, please provide us with the alternative address. Please note that our mail will not forward, even if you have a forwarding order with the U.S. Post Office.

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

I have reviewed all of the information on the front of this form, and confirm that all of the information is the same.

Patient's Initials Date