Southtowns Ear, Nose & Throat, LLP

Patient Information ******Please complete ALL information******

Patient Name_____ **DOB**___/____/____

Address_____

City_____**State**_____**Zip**_____-_____

Phone( )_____-_____ **Cell**( )_____-_____ **Work**( )_____-_____**ext.**____

E-mail address_____

Marital status_____ **Sex** Male Female Unknown **Race**_____

Student Status (circle**) Full Part-time N/A** **Language** (circle) **English Spanish other**

Ethnicity (circle**) Spanish/Hispanic Origin** or **Not of Spanish/Hispanic Origin**

Employer_____**Occupation**_____
Employer Address_____
City_____**State**_____**Zip**_____-_____

Work( )_____-_____**ext.**___

Responsible party_____
(Under 18 years of age or legal guardianship)
Relationship to patient_____
Address_____
Phone( )_____-_____ **Cell**( )_____-_____ **Work**( )_____-_____**ext**___

Primary Care Physician's Name_____
Address_____
Phone( )_____-_____
Referring Physician's Name_____

Pharmacy_____ **Phone**( )_____-_____
Address_____

COMPLETE NEXT PAGE

Patient Name_____ **DOB**___/___/____

******Complete ALL information for each insurance *****

Primary Insurance_____
Insured's Name_____ **DOB**____/____/_____
Insured's Employer_____
Insured's Employer Address_____
ID#_____**Group#**_____

Secondary Insurance_____
Insured's Name_____ **DOB**____/____/_____
Insured's Employer_____
Insured's Employer Address_____
ID#_____**Group#**_____

Third Insurance_____
Insured's Name_____ **DOB**____/____/_____
ID#_____**Group#**_____

How may we contact patient regarding appointments and medical information?
(Check all that apply)
Home phone____ **Cell phone**____ **Work phone**____ **With another person**____
Send Via Mail____ **Send Via Portal**____

Persons authorized to communicate all information with by the patient.
Name_____
Relationship_____ **Phone**( )_____

Name_____
Relationship_____ **Phone**( )_____

By signing this document, I acknowledge that I have received a copy of the HIPAA Privacy Notice. This acknowledgement is required by the Health Insurance Portability and Accountability Act to ensure that I have been made aware of privacy rights.

Signature_____**Date**_____

Print Name_____

Relationship if signed by responsible party_____