Southtowns Ear, Nose & Throat, LLP

Patient Information

Patient Name:____ **DOB:**___/____/____

Address:____

City:____**State:**_____**Zip:**_______-______

Phone:(   )_____-_______ **Cell:**(   )_____-_______ **Work:**(   )_____-_______**ext.**___

E-mail address:____

Marital status:____________ **Sex:** Male or Female **Race:**________________________

Student Status: Full Part-time N/A **Language:** English Spanish other

Ethnicity: 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:____

Southtowns Ear, Nose & Throat, LLP

Patient Information

Patient Name:____ DOB:___/___/____

******Please complete all information for each insurance you have******

Primary Insurance:____
Insured's Name:____________________________ DOB:____/____/______
ID#:_________________________________Group#:_____________________

Secondary Insurance:____
Insured's Name:____________________________ DOB:____/____/______
ID#:_________________________________Group#:_____________________

Third Insurance:____
Insured's Name:____________________________ DOB:____/____/______
ID#:_________________________________Group#:_____________________

How may we contact patient regarding appointments and with 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____

Print Name____ Date ________________

Relationship if signed by responsible party__________________________________