ADULT PATIENT INFORMATION

PATIENT'S NAME_____

AGE_____ DATE OF BIRTH_____ SEX_____MARITAL STATUS_____

HOME ADDRESS_____APT#_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE# (____)_____ CELL#(____)_____ EMAIL:_____

OCCUPATION_____ SS#_____

EMPLOYER'S NAME_____

EMPLOYER'S ADDRESS_____

BUS. PHONE # (____)_____ HOW LONG EMPLOYED?_____

RACE: (PLEASE CIRCLE) NATIVE AMERICAN ASIAN PACIFIC ISLANDER BLACK WHITE HISPANIC OTHER:_____

ETHNICITY: HISPANIC NON-HISPANIC OTHER:_____ PREFERRED LANGUAGE:_____

HOW WOULD YOU PREFER TO BE CONTACTED? EMAIL ☐ TEXT ☐ VOICE ☐ @ _____

YOUR COMPLAINT OR ILLNESS FOR TODAY'S APPOINTMENT:_____

DID YOUR DOCTOR ASK YOU TO SEE AN ENT DOCTOR? YES NO

IF YES, WHAT IS THE NAME OF THAT PHYSICIAN?_____

HAVE ANY OF YOUR FAMILY MEMBERS BEEN SEEN IN THIS PRACTICE? YES ☐ NO ☐

IF SO, WHO?_____

HOW DID YOU HEAR ABOUT US? FRIEND ☐ PUBLICATION ☐ INSURANCE ☐ INTERNET ☐ PHYSICIAN ☐

OTHER ☐ _____

Please complete this section if your insurance is through your SPOUSE'S place of employment.

INSURED INFORMATION:

IF OTHER THAN PATIENT: NAME:_____ DOB_____

RELATIONSHIP TO PATIENT_____

ADDRESS (IF DIFFERENT THAN PATIENT)_____APT #_____

HOME PHONE #(____)_____MOBILE PHONE #(____)_____

OCCUPATION_____ SS#_____

EMPLOYER'S NAME_____

EMPLOYER'S ADDRESS_____

BUS. PHONE # (____)_____ HOW LONG EMPLOYED?_____

I have been given an opportunity to read and understand your notice of privacy practices.

I authorize the release of any medical or other information to my insurance carrier, referring physician or to the following individuals:

_____

I authorize payment of medical benefits for myself or my dependents to Clear Lake Medical Center ENT or Bay Area Audiology. I understand that I am responsible for any amount not covered by insurance.

_____ _____ _____

Today's Date Signature Relationship to Patient