

Welcome To Our Office

**Allergy
Ear Nose
& Throat** INSTITUTE
EXCELLENCE SINCE 1992



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How did you hear about us? Family/Friend Website Physician Referral Phonebook Facebook
 Billboard Newspaper TV Commercial Magazine Other _____

Referring Physician: _____ Family Physician: _____

PATIENT DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ Age: _____ Sex: Male Female SSN: _____ - _____ - _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Email: _____

(Confidential)

Employer: _____ City: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____ or _____

(Name)

Your preferred method of contact: Cell Phone Home Phone Work Phone Email Text Message

PARENT / GUARDIAN OF MINOR / FINANCIAL RESPONSIBLE PARTY DEMOGRAPHIC INFORMATION

*The financial responsible party is the parent / guardian who will be signing below and accepting financial responsibility.

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ Age: _____ Sex: Male Female SSN: _____ - _____ - _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Email: _____

(Confidential)

Employer: _____ City: _____ Work Phone: _____

POLICY HOLDER INSURANCE COVERAGE INFORMATION

Primary Insurance: _____ Policy Number: _____ Grp. Number: _____

Policy Holder: _____ DOB: _____ SSN: _____ Effective Date: _____

Home Phone: _____ Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____ City: _____ Work Phone: _____

Secondary Insurance: _____ Policy Number: _____ Grp. Number: _____

Policy Holder: _____ DOB: _____ SSN: _____ Effective Date: _____

Home Phone: _____ Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____ City: _____ Work Phone: _____