



**PATIENT INFORMATION (PLEASE PRINT)**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  
Last Name First Middle Init.

ADDRESS: \_\_\_\_\_  
Street City State Zip

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

E-MAIL \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ RETIRED FROM: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**If bill is to be sent to someone other than patient please provide following information:**

NAME \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

1. \_\_\_ **Phone Book**
2. \_\_\_ **Our Website**
3. \_\_\_ **Friend**
4. \_\_\_ **Referral from Physician:**  
... **Are they an Ear, Nose & Throat Doctor?** \_\_\_ **Yes** \_\_\_ **No**  
... **Doctor's Name** \_\_\_\_\_
5. \_\_\_ **Newspaper**
6. \_\_\_ **Verizon Superpages on Internet**
7. \_\_\_ **Other** \_\_\_\_\_