Patient Information Form

TUCSON E.N.T ASSOCIATES, P.C.

Patient Information

First Name | **Middle Initial** | **Last Name**

Address | **City** | **State** | **Zip Code**

Email | **Preferred Language** | **SSN** | **Date of Birth**

Primary Phone Number | **Phone Type** Cell or Home | **Secondary Phone Number** | **Phone Type** Cell or Home

Gender Male Female | **Marital Status** | **Ethnicity** (Circle All that Apply) Hispanic/Latino | Not Hispanic | Declined

Race White | Black or African American | America Indian or Alaskan Native | Asian | Native Hawaiian or Other Pacific Islander | Hispanic | Declined

Employer Name | **Employer Phone**

Emergency Contact Name | **Emergency Contact Phone** | **Relationship to Patient**

Referring Physician | **Primary Care Physician**

Insurance Information

Primary Insurance | **Member #** | **Group #**

Primary Insured Name | **SSN** | **Relationship** | **Date of Birth** | **Gender**

Secondary Insurance | **Member #** | **Group #**

Secondary Insured Name | **SSN** | **Relationship** | **Date of Birth** | **Gender**

Financial Responsible Party

Responsible Party Name | **SSN** | **Relationship to Patient** | **Primary Phone**

Address | **Date of Birth** | **City** | **State** | **Zip Code**

Specific Information Release

I specifically authorize Tucson Ear, Nose & Throat to release any medical and/or billing information to persons:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Patient/Guardian Signature _____ Date: _____