Name:
DOB:
Chart:
Age:
Date:

OTOLARYNGOLOGY ASSOCIATES PHYSICIAN _____
(FOR OFFICE USE ONLY)

PATIENT NAME _____ _____ INITIAL
(LAST) (FIRST) (MIDDLE)

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ CELL PHONE ( ) _____ WORK PHONE ( ) _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH _____ / _____ / _____ AGE _____ SEX: M / F (CIRCLE ONE)

EMAIL ADDRESS (FOR PATIENT PORTAL ACCESS) _____

RACE: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ American Indian/Alaska Native ☐ White
☐ More than one race ☐ Unreported/Refused to report

ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Unreported/Refused to report LANGUAGE: _____

SPOUSE _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

CHILD'S MOTHER/GUARDIAN _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

CHILD'S FATHER/GUARDIAN _____ / /
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

ADDRESS IF DIFFERENT THAN PATIENT'S _____

REFERRING M.D. _____ /
(ADDRESS)

FAMILY M.D. _____ /
(ADDRESS)

NOTIFY IN CASE OF EMERGENCY _____ / _____ PHONE ( ) _____
(RELATIONSHIP)

PHARMACY _____ LOCATION _____ PHONE ( ) _____

REASON FOR BEING SEEN TODAY _____

ANY HEARING CONCERNS: ☐ YES ☐ NO DO YOU HAVE ANY DIZZINESS: ☐ YES ☐ NO

ANY PROBLEMS WITH ALLERGIES: ☐ YES ☐ NO

****THIS SECTION MUST BE COMPLETED IN FULL, EVEN IF CARD IS COPIED****

PRIMARY INSURANCE CO. _____ Employer: _____

ID# _____ GROUP # _____ POLICY HOLDER'S DATE OF BIRTH _____ / /

POLICY HOLDER'S NAME _____ ☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ STEPPARENT

SECONDARY INSURANCE CO. _____ Employer: _____

ID# _____ GROUP # _____ POLICY HOLDER'S DATE OF BIRTH _____ / /

POLICY HOLDER'S NAME _____ ☐ PATIENT ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ STEPPARENT