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Diplomate American Board of Otolaryngology

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Patient Information Form

Patient Information

Last Name: _____ First Name: _____ M.I. ____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ male ☐ female

Social Security #: _____ Street Address: _____

Driver's License #: _____ _____

Date of Birth: _____ Age: _____ State: _____ Zip: _____

Name of Employer: _____ Home Phone: _____

Employer Phone: _____ Cell Phone: _____

Policy Holder (If different from Patient)

Last Name: _____ First Name: _____ M.I. ____ Sex: ☐ male ☐ female

Social Security #: _____ Street Address: _____

Driver's License #: _____ _____

Date of Birth: _____ Age: _____ State: _____ Zip: _____

Name of Employer: _____ Home Phone: _____

Employer Phone: _____ Cell Phone: _____

Spouse Information (If different from above)

Last Name: _____ First Name: _____ M.I. ____ Sex: ☐ male ☐ female

Social Security #: _____ Street Address: _____

Driver's License #: _____ _____

Date of Birth: _____ Age: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

General Information

Family Physician Name: _____ Physician's Phone: _____

Nearest Relative (not living with you): _____ Relative's Phone: _____

Emergency Contact: _____ Relation: _____ Emergency Phone: _____

Insurance Information

Primary Insurance Plan: _____ Policy Holder's Name: _____

ID: _____ Group: _____ Provider's Phone: _____

Secondary Insurance Plan: _____ Policy Holder's Name: _____

ID: _____ Group: _____ Provider's Phone: _____

HIPAA Information: Instructions for the office when returning phone calls or appointment reminders.

I authorize to be contacted at: ☐ Home ☐ Work ☐ Cell and may leave messages at: ☐ Home ☐ Work ☐ Cell

I authorize the office to leave detailed messages about appointments and health information: ☐ Yes ☐ No

Messages may be left with the following individuals: _____ _____ _____

Patient (or Parent/Guardian) Signature: _____ **Date:** _____