

PATIENT INFORMATION - PLEASE PRINT

ALL OF THE FOLLOWING MUST BE ANSWERED FULLY IN **ORDER FOR US TO HELP YOU WITH YOUR INSURANCE NEEDS**

NAME _____	DATE _____	PERSON INSURED _____
C/O _____	RELATIONSHIP:	SELF _____ SPSE _____ CHILD _____ OTHER _____
ADDRESS _____		
CITY, STATE _____		
ZIP _____ TELEPHONE () _____	PRIMARY INSURANCE COMPANY:	
DATE OF BIRTH _____ SEX _____	NAME _____	
AGE _____	ADDRESS _____	
PATIENT'S SS NO. _____	CITY, STATE _____	
MARITAL STATUS: ___ MARRIED ___ SINGLE ___ WIDOW ___ DIVORCED	ZIP _____	
PARENTS FIRST NAME: MOTHER _____	POLICY NO. _____	
FATHER _____	GROUP NO. _____	
EMERGENCY CONTACT _____	SECONDARY INSURANCE COMPANY:	
TELEPHONE NO. _____	NAME _____	
EMPLOYER _____	ADDRESS _____	
ADDRESS _____	CITY, STATE _____	
CITY, STATE, ZIP _____	ZIP _____	
TELEPHONE NO. _____	POLICY NO. _____	
	GROUP NO. _____	

PRIMARY CARE DOCTOR OR REFERRING DOCTOR

NAME _____ ADDRESS _____
CITY, STATE, ZIP _____ PHONE NO. _____

PRESENT PROBLEM: EAR () NOSE () THROAT ()

MAIN COMPLAINT: _____

ALLERGIES TO MEDICATION: _____

SIGNATURE _____