CONFIDENTIAL PATIENT INFORMATION

Patient Name ____ Date _____________________

____
Address (P.O. Box/Apt. #) City State Zip Code

Phone (Home): ___________________ (Work) ____________________ (Cell): ___________________

Would it be more convenient to receive a text message? Yes [ ] No [ ]

Date of Birth _____________ Age: _____ E-Mail address: ____________________________________

Insurance Company: ____

Gender: M / F Are you Diabetic Yes [ ] No [ ]

How did you hear about our Hearing Center? ___________________________________

Who referred you to our office? ____
May we contact you / leave you a message: Home phone Yes [ ] No [ ] Cell phone Yes [ ] No [ ]
Work phone Yes [ ] No [ ] E-Mail Yes [ ] No [ ] Mail Yes [ ] No [ ] Text message Yes [ ] No [ ]

Current Family Physician's Name: ____

____
Address City State Zip Code Phone

Current Ear Nose Throat Doctors Name: ____

____
Address City State Zip Code Phone

May we send a report of your visit to your ENT and Family Physician? Yes [ ] No [ ]

Emergency contact: _________________________________ Telephone: ________________________

Spouse's/Significant other's Name: ____

Do you consent for us to communicate with your Spouse/Significant Other? Yes [ ] No [ ]

Signature:____ Date Signed:______________________