urgENT
ear • nose • throat • sinus • cold • allergy

PATIENT INFORMATION RECORD

Referring Doctor			**Date**	
Patient's Name	**Marital Status**	**Date of Birth**	**Age**	**Sex**
Street Address	**Home Phone**	**Cell Phone**	**Social Security No.**	
City, State, Zip Code	**Spouse's Name**		**Date of Birth**	
Patient's Employer	**Business Phone**			
Patient's Occupation				
Insurance # 1	**Name of Insured**		**Date of Birth:**	
Insurance #2	**Name of Insured**		**Date of Birth:**	
Relative or Friend (Not Living With You)	**Address**		**Phone No.**	
Are you HIV Positive? _____YES _____NO	**Do You Have any drug allergies?** No Yes If yes Explain		**Do You Have Any Serious Medical Problems?** No Yes If yes Explain	

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE CARRIER AND PAYMENT DIRECTLY TO MY PHYSICIAN FOR ALL SERVICES LISTED ON THE AITACHED HEALTH INSURANCE CLAIM FORM. I UNDERSTAND THAT SERVICES RENDERED ARE THE RESPONSIBILITY OF THE PATIENT AND NOT THE INSURANCE COMPANY.

Email Address: _____

_____

Patient or Parent's Signature

IF PATIENT IS A MINOR

Person Responsible for Payment		**Relationship**	**Phone**
Mother	**Date of Birth**	**Father**	**Date of Birth**
Social Security No.		**Social Security No.**	
Address, City, State, Zip Code		**Address, City, State, Zip Code**	
Home Phone	**Work Phone**	**Home Phone**	**Work Phone**
Employer		**Employer**	

REFERRAL SOURCE:

Friends **Internet** **Commercial/Billboard** **Physician**_____

Other_____