

High Country Ear, Nose, & Throat

• Patient Information

Today's date _____

Name _____ SSN _____ DOB _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Sex _____ Marital Status _____

Home Ph (____) _____ Work (____) _____ Cell (____) _____

Employer _____ Employer Ph (____) _____ ext # _____

Referred by: (circle one) physician, phonebook, newspaper, internet, friend/family _____

Referring Dr. _____ Primary Dr. _____

• Emergency Contact

Name _____ Relation _____ Phone _____

• Release of Medical information

My medical information may be released to the following family member or other given person:

Name _____ Relation _____ Date _____

• Financially Responsible

Please check if patient is responsible, if other please fill out below.

Name _____ Relation _____ Phone (____) _____

Address _____ City _____ State _____ Zip Code _____

Home Ph (____) _____ Work (____) _____ Cell (____) _____ Sex _____

Employer _____ Employer Phone (____) _____

• Insurance Information

Primary _____ Secondary _____

Subscriber Name _____ Subscriber Name _____

ID _____ Group _____ ID _____ Group _____

Copay \$ _____ DOB _____ Copay \$ _____ DOB _____

SSN _____ SSN _____

****If patient is a Minor/Child, Please fill out below****

Mother's Information

Name _____

DOB _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

Home _____ Cell _____

Employer _____ Ph _____

Father's Information

Name _____

DOB _____ SSN _____

Address _____

City _____ State _____ Zip Code _____

Home _____ Cell _____

Employer _____ Ph _____