comprehensiveENT
care for all ages

PATIENT INTAKE

Patient Record (Please Print)

Name: _____ Date: _____

Patient's Social Security Number: _____ Date of Birth: _____

Street: _____ Apt/Suite #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellphone: _____ Email: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____

Work Phone: _____ Personal Phone: _____

Apt/Suite #: _____

City: _____ State: _____ Zip: _____

Person Responsible for Bills (If Different Than Patient)

Name: _____ Relationship: _____

Social Security Number: _____ Date of Birth: _____

Street: _____ Apt/Suite #: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Personal Phone: _____

Insurance Information

Primary Insurance Company: _____ Insured's Name: _____

Policy #: _____ Group#: _____ Insured's DOB: _____

Secondary Insurance Company: _____ Insured's Name: _____

Policy #: _____ Group#: _____ Insured's DOB: _____

Referring Physician: _____

Primary Care Physician: _____

Preferred Pharmacy: _____

Address of Pharmacy: _____

How did you find out about us?

☐ Physician Referral ☐ Internet ☐ Friend or Relative ☐ Insurance Website ☐ Other: _____

Please Read:

Do you have an advance medical directive on file? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No Do you have a medical POA? ☐ Yes ☐ No

Signature: _____ Date: _____

(If minor or dependent, parent or guardian's signature required)

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