Welcome to our office
SUBURBAN EAR, NOSE & THROAT ASSOCIATES, LTD.
Patient Information – PLEASE PRINT

Name (Last)____________________________ (First)_______________ (Middle)__________

Address____

City_________________________________ State____________ Zip code________________

Please check the box next to the best number to reach you

☐Home phone___________________________☐Work phone ____________________ext____

☐Cell phone ________________________ Email_____________________________________

Please contact me by ☐ phone number checked above or ☐ mail

SSN_______________________ Birthdate_____________________ Age_______ Sex______

Race: ☐White ☐American Indian/Alaska Native ☐Asian ☐Black/African American
☐Nat Hawaiian/Pacific Islander ☐Other Race ☐Unknown ☐Declined

Primary Language:_________________________

Are you of Hispanic/Latino descent? ☐ Yes ☐ No

Marital status: ☐Married ☐Widowed ☐Divorced ☐Separated ☐Single ☐Minor

Current Occupation (if employed)____ ☐Student

If you are unavailable when we call you, may we leave medical information with another person and/or do you authorize any other person to call regarding your medical information?
☐ Yes ☐ No If yes, with whom?________________________________

****
Local Pharmacy Address:_____________________________________

Name:___________________________ City:____
****
If patient is a minor, please provide the other parents' work and cell phone numbers below.

Work phone___________________________ext________ Cell phone____________________
****
Person to notify in case of an emergency (other than listed above):

Name_______________________________________ Phone number_____________________

Insured Information:

Relationship to patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Guardian ☐Other

Name____ Home phone_____________________

Address____

City_______________________________ State__________ Zip code_______________________

Employer____

Insured Date of Birth__________________________ SSN______________________________

Work phone_____________________________ext________ Cell phone_____________________

I authorize payment of medical benefits to the listed physicians at Suburban Ear, Nose & Throat Associates, Ltd. I authorize release of my medical information to the insurance company to help pay on any of my claims.

Patient/Guardian Signature___________________________________Date____________________

Please be aware that some services provided in our office may not be covered by your co-pay and may be subject to your deductible. Our office does not know this until we receive the explanation of benefits from your insurance carrier.

I understand the above statement and agree to be responsible for any amount not covered by my insurance.

Patient/Guardian Signature___________________________________Date____________________