ENT and Allergy Associates of Florida, P.A. – Patient Information

Please Fill Out Form Completely

Salutation/Titular: Mr.___ Mrs.___ Ms.____Miss____ Dr.____

Patient Name: _____

Date of Birth:_____ Age:_____

Sex: F____ M ____ Marital Status: M ___ S___ D ___ W___ Other___

Please check appropriate response:

*** *Race: American Indian/Alaska Native_____ Asian_____ Black/African American_____ Declined to answer _____**

Native Hawaiian/Pacific Islander_____ Other Race____ White_____

Please check appropriate response:

****Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____**

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name:_____

Patient's Address:_____

Street City, State Zip

Patient's 2nd Address:_____ _____Full-time _____Part-time Resident

Patient's Phone (Primary) (_____)_____Patient's Phone (Cell) (_____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Email Address:_____ Employer Name:_____

Emergency Contact:_____Relationship:_____Phone#_____

Whom may we thank for referring you?_____

Referring Physician:_____ Primary Care Physician:_____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

Pharmacy Name_____Address:_____Tele#_____

Insurance Information

Primary Insurance Company:_____ Subscriber's Name:_____ _____

Relationship to Patient:_____Date of Birth:_____ID#_____Group#_____

Secondary Insurance Company:_____ Subscriber's Name:_____

Relationship to Patient:_____ Date of Birth:_____ID#_____Group#_____

I also authorize my Physician and ENT and Allergy Associates of Florida, P.A. to photograph me for medically related documentation purposes. Yes_____ No_____

Signature:_____Date:_____