Tallahassee Ear, Nose & Throat-Head & Neck Surgery, P.A.

TODAY'S DATE: _____ **FOR TODAY'S VISIT YOU WILL BE PAYING:** ___**Cash** ___**Check** ___**Credit Card**

PATIENT INFORMATION:

Primary Care Physician:_____ Referring Physician: _____

Last Name: _____First Name: _____ Middle Initial: ___ Age: _____

Social Security #: _____ Birthdate: ____/____/_____Gender: M F X Marital Status: ___

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Race: _____ Ethnicity: Hispanic / Non-Hispanic Language: _____
(Please circle one above)

Primary #: (_____) _____ Cell #: (____) _____

Work #: (____) _____ Home #: (____) _____

Email: _____

CONFIRMATION PREFERENCE:

☐ **TEXT**

☐ **CALL**

☐ **EMAIL**

PRIMARY INSURANCE CARRIER:

Insured's Name: _____

Insured's Address: _____

City: _____ State: ____ Zip: _____

Insured's DOB: _____/_____/_____

SECONDARY INSURANCE CARRIER:

Insured's Name: _____

Insured's Address: _____

City: _____ State: ____ Zip: _____

Insured's DOB: _____/_____/_____

Please submit insurance card for scanning. If no insurance card is available, please complete the following information:

Insurance Co: _____

Policy Number: _____

Insurance Co: _____

Policy Number: _____

PARENT/LEGAL GUARDIAN INFORMATION

If the patient is under the age of 18 or insurance is maintained by someone else; please complete the following:

If you are the grandparent or step-parent do you have legal guardianship of the patient? Yes No

****You must have court ordered paperwork on hand in order for the patient to be seen. Please submit paperwork so it may be filed in the chart and complete the information below:**

Name: _____ DOB: ___/____/____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone: (_____)_____Ext_____

Relationship: (please circle one) Mother Father Grandparent Step-Parent Legal Guardian Other _____