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: __________________________________ Insurance Co: ________________________________

Policy Number: ________________________________ 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 ____________