Oregon Ear, Nose, and Throat Center
Patient Information

Doctor/audiologist_____ Patient ID#_____

PATIENT INFORMATION

Name: _____
Last First Middle

Address: _____

_____
City State Zip code

Home phone _____

Work phone _____

Mobile phone _____

Other phone _____

Email _____

Gender: ☐ Male ☐ Female

Social Security # _____

Date of Birth _____
Month Day Year

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Domestic partner

Referring healthcare provider_____

Primary healthcare provider_____

PATIENT'S EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Student ☐ Other _____

Employer _____

Phone _____

EMERGENCY CONTACT

Name _____
Last First Middle

Relationship to patient_____

Phone _____

GUARANTOR INFORMATION

☐ Same as patient ☐ Other (fill in information in this box)

Name _____
Last First Middle

Address: _____

_____
City State Zip code

Employer_____

Social Security # _____

Date of Birth _____

Home phone _____

Work phone _____

If insured, please fill in the following information and be prepared to present your insurance cards to the reception desk when you check in.

PRIMARY INSURANCE INFORMATION

☐ Patient's ☐ Guarantor's ☐ Other_____

Insured Party Name_____
Last First Middle

Relationship to insured_____

Social Security number _____

Insured's Date of Birth_____

Insured Phone_____

Insured's Employer_____

Insurance Company_____

Insured ID #_____

Policy Group #_____

Plan #_____

SECONDARY INSURANCE INFORMATION

☐ Patient's ☐ Guarantor's ☐ Other_____

Insured Party Name_____
Last First Middle

Relationship to insured_____

Social Security number _____

Insured's Date of Birth_____

Insured Phone_____

Insured's Employer_____

Insurance Company_____

Insured ID #_____

Policy Group #_____

Plan #_____

AUTHORIZATION: I hereby authorize The Oregon Ear, Nose, and Throat Center to release to my attorney(s), Insurance Carrier(s), and/or referring practitioner medical information required or requested. I hereby assign all medical and/or surgical benefits, including major medical benefits, for medical services provided to The Oregon Ear, Nose, and Throat Center. This assignment will remain in effect until revoked by me in writing. Any service not covered by Insurance, Medicare or Medicaid is my responsibility. Photocopies of this assignment are considered as originals. The clinic is authorized to act as an agent for appeals on claims.

_____
Date

_____
Patient or Guardian signature

May we leave a message on your answering machine? ☐ Yes ☐ No Initial:_____
May we discuss your care with a family member? ☐ Yes ☐ No If yes, name_____Initial:_____
May we call you at work? ☐ Yes ☐ No Initial:_____
I acknowledge receipt of the Notice of Privacy Practices (HIPPA)_____
Patient or Guardian signature