OC EAR, NOSE, THROAT
HEAD & NECK SURGERY

16100 Sand Canyon Ave. Suite 230 Irvine CA 92618
Tel: (949) 715-0500 Fax: (949) 715-0504 www.ENTdoctorOC.com

PATIENT NAME: _____ DOB: _____

Parent/Guardian Name : _____ SS#: _____

Address City State Zip

Home phone Cell phone I give my permission to be contacted at/by: ___ Home ___ Cell ___ Email ___ Text Ok to leave message? __yes __ no

E-MAIL _____ What is your primary language? _____

Marital Status: __ Married __ Single __ Divorced __ Widowed __ Separated Gender __ male __female ___non-binary

INSURANCE INFORMATION (Must be filled out completely for verification purposes) **____ Check HERE if you have NO insurance**

Primary insurance company Policyholder name Policyholder DOB Patient relationship to insured __Self __Spouse __ Child __ Other

Policy # Group #

Secondary insurance company Policyholder name Policyholder DOB Patient relationship to insured __Self __Spouse __ Child __ Other

Policy # Group #

We are required to ask this question about your race: __ White or Caucasian __ Hispanic or Latino __ Black Hispanic or Latino __ Black or African American __American Indian or Alaska Native __ Native Hawaiian or Other Pacific Islander __ Asian __ Other __ I prefer to not answer

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the release and/or discussion of my health information with the following persons.This authorizes access to your medical chart.

Name_____ Relationship _____ Phone number _____

Name_____ Relationship _____ Phone number _____

Do you have an Advance Directive? ____ Living Will ? ___ Medical Power of Attorney? ___

__ Do not discuss my information with anyone. (**Information may be released per HIPAA guidelines for treatment, payment, and operations**)

PHARMACY

Name of Pharmacy Address/Cross Streets: Phone number

EMERGENCY CONTACT (This is who will be called if you have an emergency while in the office)

Name_____ Relationship _____ Phone number _____

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to of all the terms herein.

x_____ _____

Signature of patient, responsible party Date

NEW PATIENTS: Please indicate how you heard about us. Thank you!

☐ Physician ☐ Friend ☐ Word of mouth ☐ Insurance company ☐ Internet ☐ Other:

Referring Physician: **Primary Care Physician**: