Patient Demographic Form

ENT Physicians, Inc
Toledo 419-474-9324
Oregon 419-698-4505
Audiology 419-776-5028

MRN # **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Physician ❑ Radio ❑ Television ❑ Website ❑ Yellow Pages ❑ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

CONSENT

* I, as the patient or legal guardian, authorize the Insurance Carrier to make checks for medical expenses due payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the Insurance Carrier. I further understand that I am responsible for all medical expenses and agree to pay any expenses not covered by my Insurance Carrier. I understand that after my primary carrier has paid or rejected payment, I am responsible for the remaining balance and that billing my insurance is done of contractual obligation for participating carriers and is done only as a courtesy for other non-participating carriers.
* Delinquent accounts may be referred for third party collection and may be charged for associated collection and attorney/legal fees.

Signature: _____ Date: _____

- **Please bring your insurance card/s and ID card with you to the appointment**
- **Please have all paperwork filled out or completed online prior to your appointment or we may have to reschedule your appointment**