

**Patient Information**

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Appointment Date: \_\_\_\_\_ Appointment time: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ Sex: \_\_\_\_\_

Social Security #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name of Parent of Guardian (If Patient is under 18 years of Age): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ APT: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Primary Phone # (\_\_\_\_) \_\_\_\_\_

Secondary Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PERSON (s):** (Person responsible for bill if insurance does not pay or has termed)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Driver's License # \_\_\_\_\_ State: \_\_\_\_\_ we will ask to make a copy of your license

Primary Insurance: \_\_\_\_\_ 2<sup>nd</sup> Insurance: \_\_\_\_\_

Name of person who holds insurance: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

May we leave a Message on your voice mail? \_\_\_\_\_ Yes \_\_\_\_\_ No

May we leave a message at your place of employment? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list persons with whom we can discuss your (or your child's) medical information:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ Secondary Phone: (\_\_\_\_) \_\_\_\_\_

I hereby authorize the release of medical information to referring doctor and/ or any doctor to whom Dr. Ashley Hall may refer me. I authorize my family or referring doctor to release my records to Dr. Ashley Hall. I authorize the release of medical information necessary to process insurance claims and request payments of insurance benefits be made to ENT ALLERGY, ASTHMA, & IMMUNOLOGY CENTER. I hereby affirm that all information provided by me is true to the best of my knowledge, and will accept financial responsibility for my account with ENT ALLERGY, ASTHMA & IMMUNOLOGY CENTER.

Patient's Signature (or Parent/ guardian): \_\_\_\_\_ Date: \_\_\_\_\_