



# ENT Patient Information Sheet

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_

Male  Female  Single  Married  Divorced  Widow

Soc Sec # \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

How did you hear about Premier Medical Group? \_\_\_\_\_

Spouse Name \_\_\_\_\_ DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Work # \_\_\_\_\_

### Emergency Contact:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

### COMPLETE THE FOLLOWING IF PATIENT IS A MINOR OR STUDENT

Name of person responsible for patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Mother/Legal Guardian: \_\_\_\_\_ DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Mother/Legal Guardian Address: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Mother/Legal Guardian Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father/Legal Guardian: \_\_\_\_\_ DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Father/Legal Guardian Address: \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

Father/Legal Guardian Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent or Guardian's Signature to Treat Minor \_\_\_\_\_ Date \_\_\_\_\_