

## ADULT PATIENT INFORMATION

PATIENT'S NAME \_\_\_\_\_  
AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME PHONE# (\_\_\_\_) \_\_\_\_\_ CELL#(\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ SS# \_\_\_\_\_  
EMPLOYER'S NAME \_\_\_\_\_  
EMPLOYER'S ADDRESS \_\_\_\_\_  
BUS. PHONE # (\_\_\_\_) \_\_\_\_\_ HOW LONG EMPLOYED? \_\_\_\_\_  
RACE: (PLEASE CIRCLE) NATIVE AMERICAN ASIAN PACIFIC ISLANDER BLACK WHITE HISPANIC OTHER: \_\_\_\_\_  
ETHNICITY: HISPANIC NON-HISPANIC OTHER: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_  
HOW WOULD YOU PREFER TO BE CONTACTED? EMAIL  TEXT  VOICE  @ \_\_\_\_\_  
YOUR COMPLAINT OR ILLNESS FOR TODAY'S APPOINTMENT: \_\_\_\_\_  
DID YOUR DOCTOR ASK YOU TO SEE AN ENT DOCTOR? YES NO  
IF YES, WHAT IS THE NAME OF THAT PHYSICIAN? \_\_\_\_\_  
HAVE ANY OF YOUR FAMILY MEMBERS BEEN SEEN IN THIS PRACTICE? YES  NO   
IF SO, WHO? \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US? FRIEND  PUBLICATION  INSURANCE  INTERNET  PHYSICIAN   
OTHER  \_\_\_\_\_

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**Please complete this section if your insurance is through your SPOUSE'S place of employment.**

### INSURED INFORMATION:

IF OTHER THAN PATIENT: NAME: \_\_\_\_\_ DOB \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS (IF DIFFERENT THAN PATIENT) \_\_\_\_\_ APT # \_\_\_\_\_  
HOME PHONE #(\_\_\_\_) \_\_\_\_\_ MOBILE PHONE #(\_\_\_\_) \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ SS# \_\_\_\_\_  
EMPLOYER'S NAME \_\_\_\_\_  
EMPLOYER'S ADDRESS \_\_\_\_\_  
BUS. PHONE # (\_\_\_\_) \_\_\_\_\_ HOW LONG EMPLOYED? \_\_\_\_\_

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I have been given an opportunity to read and understand your notice of privacy practices.

I authorize the release of any medical or other information to my insurance carrier, referring physician or to the following individuals:

\_\_\_\_\_  
I authorize payment of medical benefits for myself or my dependents to Clear Lake Medical Center ENT or Bay Area Audiology. I understand that I am responsible for any amount not covered by insurance.

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient