

DEPENDENT PATIENT INFORMATION

PATIENT'S NAME _____
AGE _____ DATE OF BIRTH _____ SEX _____
HOME ADDRESS _____ APT# _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE# (____) _____ CELL#(____) _____ EMAIL: _____
PATIENT STATUS: EMPLOYED FULL TIME STUDENT PART TIME STUDENT UNDER AGE 6
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 @ _____
PATIENT'S 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 _____

MOTHER'S NAME _____ D.O.B _____
ARE THE ADDRESS AND PHONE NO. THE SAME AS THE PATIENTS? YES NO
IF NOT THEN _____
_____ HOME PHONE NO. _____
OCCUPATION _____ SS # _____
EMPLOYER'S NAME _____
EMPLOYER ADDRESS _____
BUS PHONE NO. (____) _____ HOW LONG EMPLOYED? _____
FATHER'S NAME _____ D.O.B _____
ARE THE ADDRESS AND PHONE NO. THE SAME AS THE PATIENTS? YES NO
IF NOT THEN _____
_____ HOME PHONE NO. _____
OCCUPATION _____ SS # _____
EMPLOYER'S NAME _____
EMPLOYER ADDRESS _____
BUS PHONE NO. (____) _____ HOW LONG EMPLOYED? _____

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 Joel Berman MD, PA or Bay Area Audiology. I understand that I am responsible for any amount not covered by insurance.

Today's Date Signature Relationship to Patient