

Patient Information Form
TUCSON E.N.T ASSOCIATES, P.C.

Patient Information						
First Name		Middle Initial		Last Name		
Address			City	State	Zip Code	
Email		Preferred Language		SSN	Date of Birth	
Primary Phone Number		Phone Type Cell or Home		Secondary Phone Number		Phone Type Cell or Home
Gender		Marital Status		Ethnicity (Circle All that Apply)		
Male Female				Hispanic/Latino Not Hispanic Declined		
Race		White Black or African American		America Indian or Alaskan Native		Asian Native Hawaiian or Other Pacific Islander Hispanic Declined
Employer Name			Employer Phone			
Emergency Contact Name			Emergency Contact Phone		Relationship to Patient	
Referring Physician			Primary Care Physician			
Insurance Information						
Primary Insurance		Member #			Group #	
Primary Insured Name		SSN	Relationship	Date of Birth	Gender	
Secondary Insurance		Member #			Group #	
Secondary Insured Name		SSN	Relationship	Date of Birth	Gender	
Financial Responsible Party						
Responsible Party Name		SSN	Relationship to Patient		Primary Phone	
Address		Date of Birth	City	State	Zip Code	
Specific Information Release						
I specifically authorize Tucson Ear, Nose & Throat to release any medical and/or billing information to persons:						
Name _____		Relationship _____		Phone _____		
Name _____		Relationship _____		Phone _____		
Name _____		Relationship _____		Phone _____		

Patient/Guardian Signature _____

Date: _____