PATIENT INFORMATION - Please complete all fields

Patient Name _____ Birth date _____
First Initial Last

Last Four of SS # _____ Sex ☐ M ☐ F Race _____

Ethnicity _____ Preferred language _____

Marital Status _____ Employer _____

Patient Address _____ Please check the box to indicate your preferred contact number

_____ ☐ Home Phone _____

City / State / Zip _____ ☐ Cell Phone _____

Email Address _____ ☐ Work Phone _____

Emergency Contact and Phone # of Person Not Living With Patient _____

FAMILY CARE / PEDIATRICIAN / REQUESTING PHYSICIAN (Dr that requested you see Buckhead ENT)

Name _____ Street Address _____

Practice Name _____ City / State / Zip _____

Phone _____ Fax _____

PARENT / GUARANTOR INFORMATION - Please fill out completely for all responsible parties

Primary Contact Parent / Guarantor

Name _____

Relationship to Patient _____

Social Security _____ Birth date _____

Address _____

_____

Home Phone _____

Work Phone _____

Can you receive calls at work? ☐ Yes ☐ No

May we leave you a voice mail message? ☐ Yes ☐ No

Email address _____

Occupation _____

Employer _____

Secondary Contact Parent / Guarantor

Name _____

Relationship to Patient _____

Social Security _____ Birth date _____

Address _____

_____

Home Phone _____

Work Phone _____

Can you receive calls at work? ☐ Yes ☐ No

May we leave you a voice mail message? ☐ Yes ☐ No

Email address _____

Occupation _____

Employer _____

INSURANCE INFORMATION - failure to complete all fields may prevent us from filing a claim on your behalf

Primary Insurance

Insurance Name _____

ID # / Group # _____

Subscriber Name _____

Relationship to Patient _____

Subscriber Birth date _____

Secondary Insurance

Insurance Name _____

ID # / Group # _____

Subscriber Name _____

Relationship to Patient _____

Subscriber Birth date _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Buckhead ENT's notice of privacy practice.**

Responsible Party Signature: _____ ***Date:*** _____