**Austin Ear, Nose & Throat Clinic** **My appointment is with:**

## PATIENT DEMOGRAPHIC SHEET

### PATIENT INFORMATION

| PATIENT NAME | Date of Birth | SSN# | MARITAL STATUS ☐ Single ☐ Married ☐ Divorced |
|---|---|---|---|
| ADDRESS | CITY | ST | ZIP |
| HOME PHONE | | MOBILE PHONE | |

**ETHNIC ORIGIN**
☐ White ☐ Hispanic or Latino ☐ Black or African American ☐ Native American or American Indian ☐ Asian/Pacific Islander ☐ Other

| GENDER ☐ Male ☐ Female | EMAIL ADDRESS |
|---|---|

**PRIMARY LANGUAGE**
☐ English ☐ Spanish ☐ Italian ☐ Chinese ☐ French ☐ Dutch ☐ Russian

| | | |
|---|---|---|
| PATIENT'S EMPLOYER | Address | Phone |
| EMERGENCY CONTACT | Relationship to patient | Phone |
| NAME OF REFERRING DOCTOR | Address | Phone |
| NAME OF PRIMARY CARE DOCTOR | Address | Phone |
| List other doctors you're seeing for today's problem | | |
| PHARMACY NAME | Address | Phone |

### INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| **Primary Insurance** | Effective Date | Name of Policy Holder, Relationship and Date of Birth | Insurance Phone # |
| ID# | Group# | SSN# | |
| **Secondary Insurance** | Effective Date | Name of Policy Holder, Relationship and Date of Birth | Insurance Phone # |
| ID# | Group# | SSN# | |

### Consent

**I GIVE MY CONSENT FOR AUSTIN EAR, NOSE & THROAT CLINIC TO DISCUSS PATIENT'S MEDICAL CARE AND PAYMENT FOR MEDICAL CARE WITH THE FOLLOWING PEOPLE:**

_____ _____
Name / Relationship / Phone Number Name / Relationship / Phone Number

_____ _____
Name / Relationship / Phone Number Name / Relationship / Phone Number

### PATIENTS – PLEASE READ AND SIGN AGREEMENT

1. **I hereby give my consent for physicians of Austin Ear, Nose & Throat Clinic to evaluate and treat the above-named patient.**
2. **I have been provided the Notice of Privacy Practices for Austin Ear, Nose & Throat Clinic.**
3. **I understand that my personal health information will be used for the purpose of treatment, payment and the coordination of health care needs of the patient.**
4. **I have also been provided and agree with the Financial Policy of Austin Ear, Nose & Throat Clinic.**
5. **I understand that I am personally responsible for all provider charges if I choose to seek "out-of-network" services from this provider.**

**Signature of patient or guardian: _____ Date: _____**