

**PATIENT DEMOGRAPHIC SHEET**

PATIENT INFORMATION			
<b>PATIENT NAME</b>	<b>Date of Birth</b>	<b>SSN#</b>	<b>MARITAL STATUS</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
<b>ADDRESS</b>	<b>CITY</b>	<b>ST</b>	<b>ZIP</b>
<b>HOME PHONE</b>		<b>MOBILE PHONE</b>	
<b>ETHNIC ORIGIN</b> <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Black or African American <input type="checkbox"/> Native American or American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other			
<b>GENDER</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>EMAIL ADDRESS</b>		
<b>PRIMARY LANGUAGE</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Italian <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Dutch <input type="checkbox"/> Russian			
<b>PATIENT'S EMPLOYER</b>	Address	Phone	
<b>EMERGENCY CONTACT</b>	Relationship to patient	Phone	
<b>NAME OF REFERRING DOCTOR</b>	Address	Phone	
<b>NAME OF PRIMARY CARE DOCTOR</b>	Address	Phone	
<b>List other doctors you're seeing for today's problem</b>			
<b>PHARMACY NAME</b>	Address	Phone	
INSURANCE INFORMATION			
<b>Primary Insurance</b>	Effective Date	Name of Policy Holder, Relationship and Date of Birth	Insurance Phone #
ID#	Group#	SSN#	
<b>Secondary Insurance</b>	Effective Date	Name of Policy Holder, Relationship and Date of Birth	Insurance Phone #
ID#	Group#	SSN#	
Consent			
<b>I GIVE MY CONSENT FOR AUSTIN EAR, NOSE &amp; THROAT CLINIC TO DISCUSS PATIENT'S MEDICAL CARE AND PAYMENT FOR MEDICAL CARE WITH THE FOLLOWING PEOPLE:</b>			
_____		_____	
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: _____			

**PATIENT INFORMATION PAGE FOR A CHILD OR DEPENDENT ADULT**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

<b>First Responsible Party (Parent or Guardian of a minor under 18 or dependent child)</b>				
<b>1st Guardian's Name</b>	Date of Birth	Relationship	SSN	Driver's License #
Address	City	State	ZIP	Email
Home Phone #	Mobile Phone #			
1st Guardian's Employer	Occupation	Business Phone #		
<b>Second Responsible Party (Parent or Guardian of a minor under 18 or dependent child)</b>				
<b>2nd Guardian's Name</b>	Date of Birth	Relationship	SSN	Driver's License #
Address	City	State	ZIP	Email
Home Phone #	Mobile Phone #			
2nd Guardian's Employer	Occupation	Business Phone #		
<b>Divorced Parents</b>				
<p>In the case of divorced parents or shared custody arrangements, the court specifies the healthcare responsibilities for the child and boundaries of the involved parties. If the patient is a child of divorced parents or shared custody, please answer the following questions based on the court document that specifies the child's healthcare needs.</p> <p>According to the decree, which parent may consent to treatment and coordination of healthcare needs (not surgical): _____</p> <p>According to the decree, which parent may give consent for surgical procedures (invasive procedures): _____</p>				
<b>CONSENT FOR MINORS OR DEPENDENT ADULTS</b>				
<b>IMPORTANT NOTE: On all initial consultations, the legal parent or guardian MUST BE PRESENT</b>				
Please state who may bring the child in for follow-up other than the legal parent or guardian:				
<b>Name</b>	Address	Relationship	Phone #	
<b>Name</b>	Address	Relationship	Phone #	
<b>Name</b>	Address	Relationship	Phone #	
<b>Name</b>	Address	Relationship	Phone #	
<b>THIS CONSENT REMAINS IN PLACE UNTIL REVOKED IN WRITING OR CHILD IS NO LONGER A MINOR</b>				