Willamette Ear, Nose, Throat and Facial Plastic Surgery, LLP

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: (First, MI, Last)			Sex: [ ] M [ ] F
Birth Date:	Age:	SS#:	Email:
Race:	Ethnicity:		Language:
Mailing Address:			Interpreter Needed: [ ] Yes [ ] No
City:	State:	Zip Code:	Home Ph: ( )
			Cell Ph: ( )
Patient's Employer/Company:			Occupation:
For Minor Patients:	Father:	Mother:	Guardian:

GENERAL INFORMATION

How were you referred to this clinic? PCP [ ] Specialist [ ] Newspaper [ ] Website [ ] Yellow Pages [ ] Other __________

Who is your Primary Care Physician? Office Ph: ( )

Are you a former patient? [ ] No. [ ] Yes. Are any family members former patients? [ ] No. [ ] Yes.

CONSENT TO SHARE HEALTH INFORMATION

If you would like to give us permission to discuss your health information with someone, OTHER than your Physician(s), please ask for our Consent to Share Health Information form.

EMERGENCY CONTACT (OUTSIDE OF YOUR HOME)

Name:	Relationship:
Cell Ph: ( )	Home Ph: ( )

FINANCIAL RESPONSIBILITY

Responsible Party's Name:	DOB:	Relationship to patient:
Responsible Party's Address: (if different from above)		
Employer:	Office Ph: ( )	
Spouse's or Parent's Name: (First, MI, Last)	Occupation:	
Spouse's or Parent's Employer:	Office Ph: ( )	

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Policy Holder:	DOB:	Policy Holder:	DOB:
Group Number:		Group Number:	
ID Number:		ID Number:	
Ins. Co. Address:		Ins. Co. Address:	

_______________________________________ _______________________

Signature of Patient or Legal Guardian Date

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