

**SOUTHEAST TEXAS EAR, NOSE AND THROAT, L.L.P.**

**Welcome to Our Office**

Date \_\_\_\_\_ Dr. Seeing Today \_\_\_\_\_ Dr. That Sent You Here \_\_\_\_\_

Patient Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M) \_\_\_\_\_

Prefer Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ ☐ Male ☐ Female

Race - ☐ Amer. Indian/Alaska Native ☐ Asian ☐ Black/African Amer ☐ Declined ☐ Nat Hawaiian/Pacific Island  
☐ Other Race ☐ Unknown ☐ White

Ethnicity - ☐ Declined ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Marital Status \_\_\_\_\_ Primary Language - ☐ English ☐ Spanish ☐ Declined ☐ Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #: Home(\_\_\_\_\_) \_\_\_\_\_ - Work(\_\_\_\_\_) \_\_\_\_\_ - Cell(\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

Contact's Home Phone (\_\_\_\_\_) \_\_\_\_\_ Contact's Alternate Phone(\_\_\_\_\_) \_\_\_\_\_

***Associated Parties – You only need to complete this section:***

***If the Patient is a minor you should include info about the Mother, Father, Guardian, Stepparent, etc.***

***If the Patient is not the insured (the person that has the insurance plan) provide the info for that person***

**1) Relationship to Patient \_\_\_\_\_**

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M) \_\_\_\_\_

Preferred Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ ☐ Male ☐ Female

Marital Status \_\_\_\_\_ Primary Language - ☐ English ☐ Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #: Home(\_\_\_\_\_) \_\_\_\_\_ - Work(\_\_\_\_\_) \_\_\_\_\_ - Cell(\_\_\_\_\_) \_\_\_\_\_ -

Fax(\_\_\_\_\_) \_\_\_\_\_ - Pager(\_\_\_\_\_) \_\_\_\_\_ - Email \_\_\_\_\_

**2) Relationship to Patient \_\_\_\_\_**

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M) \_\_\_\_\_

Preferred Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ ☐ Male ☐ Female

Marital Status \_\_\_\_\_ Primary Language - ☐ English ☐ Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone #: Home(\_\_\_\_\_) \_\_\_\_\_ - Work(\_\_\_\_\_) \_\_\_\_\_ - Cell(\_\_\_\_\_) \_\_\_\_\_ -

Fax(\_\_\_\_\_) \_\_\_\_\_ - Pager(\_\_\_\_\_) \_\_\_\_\_ - Email \_\_\_\_\_

**1<sup>st</sup> Insurance Company** \_\_\_\_\_ **Policy Holder** \_\_\_\_\_

**2<sup>nd</sup> Insurance Company** \_\_\_\_\_ **Policy Holder** \_\_\_\_\_

*I authorize the release of any medical information necessary to process this claim or provide continued medical care to a referring doctor/facility. I authorize payment of medical and surgical benefits to Southeast Texas Ear, Nose and Throat, LLP. I agree to be responsible for any payment not paid by my insurance due to lack of referral, deductible, co-insurance, pre-existing condition, etc. I consent to all services, treatment, and diagnostic procedures as ordered by my physician. I will notify the office of any insurance changes prior to treatment or surgery. This authorization will remain valid until I revoke it by written notice.*

**X** \_\_\_\_\_

Signature of Patient/Responsible Party

(ONLY PATIENT AGE 18+, PARENT OR LEGAL GUARDIAN MAY SIGN)

\_\_\_\_\_

Date