Crystal Community ENT
PATIENT INFORMATION

PATIENT NAME: _____ GENDER: M F DOB: _____

MARITAL STATUS : □MARRIED □DIVORCED □WIDOW □OTHER

ETHNICITY: □ N/A
□ HISPANIC/LATINO
□ NON HISPANIC/LATINO

RACE: □ N/A
□AMERICAN INDIAN/ALASKA NATIVE
□ASIAN
□AFRICAN AMERICAN
□NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
□CAUCASIAN

PARENT OR GUARDIAN NAME: _____RELATIONSHIP TO PATIENT: _____

LOCAL MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SECONDARY MAILING ADDRESS _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: _____CELL PHONE #: _____

OTHER PHONE #: _____ EMAIL: _____

EMPLOYER NAME: _____ WORK PHONE #: _____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT: NEAREST RELATIVE, NEIGHBOR, OR FRIEND NOT LIVING WITH YOU (IN CASE YOU CAN'T BE REACHED)

NAME: _____ PHONE #: _____

PRIMARY INSURANCE: _____ **ID#** _____
(IF NOT SUBSCRIBER PLEASE FILL OUT BELOW)
SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

SECONDARY INSURANCE: _____ **ID#** _____
(IF NOT SUBSCRIBER PLEASE FILL OUT BELOW)
SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

Patient or Legal Guardian Signature: _____**Today's Date:** _____

* All information is accurate and current per patient

Employee Initial	Date