**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: _____

HOME PHONE #: _____ CELL PHONE #: _____

OTHER PHONE #: _____ EMAIL: _____

**SECONDARY MAILING ADDRESS** _____

CITY: _____ STATE: _____ ZIP CODE: _____

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 |
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