Central ENT Consultants, PC Form updated 12/11/20

PATIENT DEMOGRAPHIC FORM

NAME (first name, middle initial, last name)____

SSN: __________________ **DOB:** ____ / ____ / ____ **SEX:** _______ **Marital Status:** ____________

HOME PHONE: ___________________________ **CELL PHONE:** _________________________

HOME ADDRESS : ____

CITY, STATE, ZIP CODE: ____

EMAIL ADDRESS:_______________________________________@______________________ **YES** **NO**
May we use this address to connect you to our Patient Portal? (online access to paperwork, appointments)

In the event of an emergency, please contact:
NAME: _______________________________ RELATIONSHIP: __________________PHONE:_______________

REFERRING PROVIDER : DR. ____(if applicable)

PRIMARY CARE PHYSICIAN:____

PRIMARY INSURANCE PROVIDER: ____
PATIENT RELATIONSHIP TO INSURED : Self / Spouse / Child / Other
NAME OF SUBSCRIBER (if not self): ____
DOB OF SUBSCRIBER: ____ / ____ / ____

SECONDARY INSURANCE PROVIDER: ____ (if applicable)
PATIENT RELATIONSHIP TO INSURED : Self / Spouse / Child / Other
NAME OF SUBSCRIBER (if not self): ____
DOB OF SUBSCRIBER: ____ / ____ / ____

FEDERAL GOVERNMENT DISCLOSURE

We are required by the federal government to report on specific demographic information of our patient base. **You are NOT required to answer the following.**

ETHNICITY ☐ Hispanic/ Latino ☐ Not Hispanic/ Latino ☐_________________ ☐ Decline to Specify

RACE ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Pacific Islander ☐ White ☐ ____________________ ☐ Decline to Specify