



ENTAA Care

Ear, Nose & Throat, Asthma & Allergy
Audiology & Hearing Aid Center
Speech & Balance Center

Date: ____/____/____

Patient Information:

Social Security Number: ____ - ____ - ____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ____/____/____ Gender: ___Male ___Female

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____ Employer: _____

Emergency Contact: _____ Contact Phone: (____) _____ - _____

Primary Care Doctor: _____ Contact Phone: (____) _____ - _____

Referring Doctor: _____ Office Phone: (____) _____ - _____

Financial Responsible: (person financially responsible if other than patient)

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____ - _____ Other Phone: (____) _____ - _____

Primary Insurance Information: (please enter the policy holders information)

Insurance Company: _____ Policy/ID Number: _____

Policy Holders Name: _____ Date of Birth: ____/____/____

Social Security Number: ____ - ____ - ____ Relationship to patient: _____

Employer: _____ Work Phone: (____) _____ - _____

Secondary Insurance Information: (please enter the policy holders information)

Insurance Company: _____ Policy/ID Number: _____

Policy Holders Name: _____ Date of Birth: ____/____/____

Social Security Number: ____ - ____ - ____ Relationship to patient: _____

Employer: _____ Work Phone: (____) _____ - _____