Patient Demographics

ENT Specialists OF ALASKA

Please fill out completely and please print neatly. Thank you.

Patient:

Last Name | First Name | Middle Initial

Mailing Address | City | State | ZIP

Home Phone | Cell Phone | Work Phone

Choose One: (•) Male ( ) Female **Marital Status:** (•) Single ( ) Married ( ) Divorced ( ) Widowed

Date of Birth | Age | Social Security Number

Email | Driver's License Number

Responsible Party if Patient is Under 18

Mother's Name	Father's Name
Mailing Address	Mailing Address
City	City
State ZIP	State ZIP
Phone	Phone
Social Security Number	Social Security Number
Email	Email
Work Number	Work Number

Primary Insurance

Insurance Company

Subscriber's Name

Date of Birth

Relationship to Patient

Policy Number

Group Number

Secondary Insurance

Insurance Company

Subscriber's Name

Date of Birth

Policy Number

Group Number

Emergency Contact – With Who You Do Not Live

Name and Relationship to Patient | Phone Number

My Health Information May Also Be Released To:

Name and relationship to patient | Name and relationship to patient

Is this a Worker's Compensation Claim? ( ) Yes (•) No

By signing below, I have read and understand the financial responsibility policy and understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I hereby consent to be treated in this clinic.

Signature | Date