FoothillsENT
ALLERGY & HEARING CENTER

PATIENT INTAKE FORM

Date: _____

Last Name: _____ First Name: _____ MI: _____ Date of Birth: ____/____/____

Preferred Name: _____ Previous Name (if applicable): _____

Address: _____ City: _____

State: _____ Zip: _____ Sex: ☐ M ☐ F OR Gender Identification (if applicable): _____

Home Phone: (____) _____ Cell: (____) _____ Work: (____) _____ Ext: _____

Email Address: _____ (if patient is a minor, please list a parent or guardian email address)

SSN: _____ Marital Status: _____

Place of Employment: _____

Have you or a family member seen us before? _____

Primary Care Physician: _____ Phone Number: (____) _____

Who referred you to us? ☐ Friend ☐ Family ☐ Physician

Referring Physician (If applicable): _____ Phone Number: (____) _____

Emergency Contact: _____ Relationship to Patient: _____

Phone Number: (____) _____

Primary Insurance Information:

Plan Name: _____

Subscriber Name (if not self): _____

Relationship: _____

Employer: _____

Subscriber DOB: _____

Secondary Insurance Information:

Plan Name: _____

Subscriber Name (if not self): _____

Relationship: _____

Employer: _____

Subscriber DOB: _____

***FEDERAL GOVERNMENT REQUIREMENT:**

Languages: ☐ English ☐ Sign Language ☐ Spanish; Castillian ☐ Other (please specify): _____

****If the patient is a MINOR****

Please list the parent(s)/guardian(s) information:

Last Name: _____ First Name: _____ MI: _____ Date of Birth: ____/____/____

Employer: _____ Relationship to Patient: _____ Responsible Party: ☐ Y ☐ N

Best Contact #: (____) _____

Last Name: _____ First Name: _____ MI: _____ Date of Birth: ____/____/____

Employer: _____ Relationship to Patient: _____ Responsible Party: ☐ Y ☐ N

Best Contact #: (____) _____

Please list any other individuals that have your permission to seek medical treatment/services for your child:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____