EAR NOSE & THROAT OF LAFAYETTE
A UNITY HEALTHCARE PARTNER

INNOVATIVE Hearing Solutions
A UNITY HEALTHCARE PARTNER

PATIENT'S INFORMATION

Patient's Social Security# _____ - _____ - _____ Date_____

Name_____
Last First Middle Initial

Home Address_____
Street Apt. City/State Zip Code

Home E-mail Address _____

Home Phone _____Mobile Phone _____

Date of Birth _____Marital Status _____ Sex: ☐ M ☐ F

Race: ☐White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other_____

Language, if not English_____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

EMERGENCY CONTACT and MISCELLANEOUS INFORMATION

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone # _____

EMPLOYER INFORMATION

(check) ☐ Full time ☐ Part time ☐ Retired ☐ Not Employed ☐ Self-employed ☐ Active Military Duty

Employer_____ Position_____

Employer's phone_____
Employer's Address_____
Street/Office # City/State Zip code

PRIMARY CARE PHYSICIAN

Physician Name:_____Phone Number:_____

REFERRAL INFORMATION

How were you referred to us (check): ☐ Employer ☐ Family member ☐ Friend ☐ Website ☐ Radio

☐ TV ☐ Newspaper ☐ Athletic Trainer ☐ Emergency Room ☐ Physician Other_____

If physician or trainer referral, please list_____

Pharmacy:_____

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PARENT INFORMATION
(if minor child)

Father's Name _____DOB:_____
Last First MI

Father's Address _____
Street Apt. City/State Zip Code

Father's Phone (home) _____Father's Phone (work) _____
Father's Employer _____SSN:_____
Father's Employer Address _____
Street City/State Zip Code

Mother's Name _____DOB:_____
Last First MI

Mother's Address _____
Street Apt. City/State Zip Code

Mother's Phone (home)_____Mother's Phone (work) _____
Mother's Employer _____SSN:_____
Mother's Employer Address _____
Street City/State Zip Code

INSURANCE INFORMATION

Primary Insurance co. _____

Subscriber's Name _____ Relationship _____
Subscriber's Address _____
Street Apt. City/State Zip Code

Employer _____ Subscriber's DOB _____ Subscriber's SS# _____

Secondary Insurance co. _____

Subscriber's Name _____ Relationship _____
Subscriber's Address _____
Street Apt. City/State Zip Code

Employer _____ Subscriber's DOB _____ Subscriber's SS# _____

Third Insurance co. _____

Subscriber's Name _____ Relationship _____
Subscriber's Address _____
Street Apt. City/State Zip Code

Employer _____ Subscriber's DOB _____ Subscriber's SS# _____

Patient Signature_____Date_____

Parent/Guardian Signature_____Date_____
(if patient is minor child)