SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

PATIENT INFO:

Patient's Legal Name: First _____ Middle _____ Last _____ ☐ Male ☐ Female

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cellphone _____ Work Phone _____ Ext. _____

Email Address _____

D.O.B. _____ Marital Status ☐ M ☐ S ☐ D ☐ W ☐ Other _____

Spouse's Name _____ D.O.B. _____

Primary Care Physician _____ Referring Physician _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ Caucasian ☐ Hispanic or Latino

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____ Preferred Language _____

Patient's Employer _____ Work Phone _____

Patient's Legal Guardian (If Applicable) _____

Father's Name (IF MINOR) _____ D.O.B. _____

Father's Home Address _____ City _____ State _____ Zip _____ Phone _____

Father's Employer _____ Occupation _____ Work Phone _____

Mother's Name (IF MINOR) _____ D.O.B. _____

Mother's Home Address _____ City _____ State _____ Zip _____ Phone _____

Mother's Employer _____ Occupation _____ Work Phone _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Subscriber # _____ Group # _____

SECONDARY INSURANCE COMPANY NAME _____ Phone _____

Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other

Subscriber D.O.B. _____ Subscriber # _____ Group # _____

TREATMENT AUTHORIZATION

I am willfully requesting treatment, and I consent to services provided by, or at the direction of, the attending provider at Southwest Idaho Ear Nose and Throat and Southwest Idaho Surgery Center. I authorize a copy of this document to be used in lieu of the original.

_____ _____

Signature of Patient or Legal Guardian — Date Signed

_____ _____

Printed Name of Patient or Legal Guardian — Relation to Patient