DEPENDENT PATIENT INFORMATION

| PATIENT'S NAME | | |
|---|--|---|
| AGE | DATE OF BIRTH | SEX |
| HOME ADDRESS | | APT# |
| CITY | STATE | ZIP CODE |
| HOME PHONE# (|) CELL#() | EMAIL: |
| RACE: (PLEASE CIRCL ETHNICITY: HISPAN HOW WOULD YOU F | E) NATIVE AMERICAN ASIAN PACIFIC IS IC NON-HISPANIC OTHER: PREFER TO BE CONTACTED? EMAIL TE | NT: |
| DID YOUR DOCTOR | ASK YOU TO SEE AN ENT DOCTOR? | YES NO |
| IF YES, WHAT IS THE | NAME OF THAT PHYSICIAN? | |
| .= | FAMILY MEMBERS BEEN SEEN IN THIS PR | ACTICE? YES NO |
| | R ABOUT US? FRIEND PUBLICATION | |
| MOTHER'S NAME | | D.O.B _ |
| ARE THE ADDRESS A | ND PHONE NO. THE SAME AS THE PATIEN | |
| | HOME PHONE NO | 0 |
| OCCUPATION | ss | # |
| | | |
| | | |
| | | MPLOYED? |
| FATHER'S NAME | | D.O.B |
| ARE THE ADDRESS A | ND PHONE NO. THE SAME AS THE PATIEN | ITS? YES NO |
| | HOME PHONE N | 0 |
| | | # |
| | | |
| | | |
| | | MPLOYED? |
| = | opportunity to read and understand your notice of any medical or other information to my ins | ce of privacy practices. surance carrier, referring physician or to the following |
| · · | f medical benefits for myself or my dependent for any amount not covered by insurance. | ts to Joel Berman MD, PA or Bay Area Audiology. I understand |
| Today's Date | Signature | Relationship to Patient |