Upper Cumberland Ear, Nose & Throat

Advanced care • Complete care • We care

Please COMPLETE this form.

Patient Last Name ______________________________ **First Name** ___________________________________ **M.I.** ___________

Sex M F **Date of Birth** __________________________ **Patient's SS#** _____________________________________

Race (Optional): Asian Black Hispanic White/ Caucasion Other ____________________

Marital Status: Married Single Widowed Divorced Seperated

Mailing Address ______________________________________ **City** ___________________________ **ST** _______ **ZIP** ____________

Preferred Contact Number: (__________) ___________________________________ **Home / Cell**

Alternate Phone Number: (__________) ______________________________________ **Home / Cell**

Emergency Phone Number: (__________) ______________________ **Whose number is this?** ______________________________

How would you prefer we contact you regarding upcoming appointments: ________ **Phone Call** __________ **Text**

Your Pharmacy _____________________________________

If Patient is a Minor: Mother ____________________________________ **Date of Birth:** ___________________________________

Father ____________________________________ **Date of Birth:** ____________________________________

Guardian _________________________________ **Date of Birth:** ____________________________________

Person Responsible for Bill ____

Patient/Guardian Employer: ____ **Work Phone** _________________________________

Spouse Name ____

Spouse Employer ____ **Work Phone** _________________________________

- - - -

First Insurance Co. _______________________________________ **Cardholder Name** ___________________________________

Cardholder SS# ____ **Cardholder Date of Birth** ____________________________

Policy/ID# ____ **Group #** ____

Second Insurance Co. ___________________________________ **Cardholder Name** ___________________________________

Cardholder SS# ____ **Cardholder Date of Birth** ____________________________

Policy/ID# ____ **Group #** ____

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Name of Doctor who sent you ________________________________ ***Family Doctor:*** __________________________________

By signing below, I acknowledge that the UCENT Privacy Notice has been made available to me. I may receive a copy upon my request.

Signature of Patient/ Guardian: ____ **Date:** _________________________