



Today's date:			Primary Physician:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Preferred name:	Social Security Number:	Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Primary address:			City/State:	Zip Code:		
Secondary address:			City/State:	Zip Code:		
Occupation:	Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		
<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital		
<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other				
Other family members seen here:						

COMMUNICATING WITH YOU	
Please check all boxes that you give Marlowe & MARRS ENT permission to use for your communications:	
Home Phone Number:	Cell Phone Number:
<input type="radio"/> You may contact me by telephone <input type="radio"/> You may leave a voicemail	<input type="radio"/> You may contact me by text message
E-mail:	*This will give you access to your records through the portal
If you give permission for us to communicate with anyone else, please complete the list below:	
Name:	Relationship:
	<input type="radio"/> Medical/ Health <input type="radio"/> Appointment <input type="radio"/> Billing
Name:	Relationship:
	<input type="radio"/> Medical/Health <input type="radio"/> Appointment <input type="radio"/> Billing

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Andrew Marlowe, MD, PA, Chad Marrs, MD or insurance company to release any information required to process my claims.			
Patient/Guardian signature		Date	