Petoskey Ear, Nose and Throat Specialists

560 West Mitchell Street, Suite 250 Petoskey, MI 49770

Main: 231-487-3277 Audiology: 231-487-3050 Fax: 231-487-6167

Patient Information

Last Name: _____ Middle Initial: ____ First Name: _____ Maiden Name: _____

Birth Date: _____ Social Security # _____-_____-_____ Nick Name: _____

Patient Race: White/Caucasian Indian/Alaska Native Asian African American/Black
Nat Hawaiian/Pacific Islander Other Race Unknown Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Declined

Marital Status: _____ Driver's License: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Billing Address (if different): _____ City: _____ State: _____ Zip: _____

Phone: (____)_____ Work: (____)_____

Cell: (____)_____ Email: _____

A *detailed* voice message may be left at the following number: (____)_____

I authorize all appointment reminders to be left for me as follows. I understand messages sent via text or email are not secure. Text ___ Email ___ Decline ___

Parent/Legal Guardian Information

Last Name: _____ Middle Initial: ____ First Name: _____ Maiden Name: _____

Birth Date: _____ Social Security # _____-_____-_____ Nick Name: _____

Patient Race: White/Caucasian Indian/Alaska Native Asian African American/Black
Nat Hawaiian/Pacific Islander Other Race Unknown Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Declined

Marital Status: _____ Driver's License: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Billing Address (if different): _____ City: _____ State: _____ Zip: _____

Phone: (____)_____ Work: (____)_____

Cell: (____)_____ Email: _____

Relation to the patient:

Father: ___ Mother: ___ Step Father*: ___ Step Mother*: ___ Legal Guardian*: ___
Spouse: ___ Child*: ___ Foster Parent*: ___ Other*: ___

**These patient relationships all require "legal authority" in order to sign. Please ask us for a form if you do not have one.*

Second Parent/Legal Guardian Information

Last Name: _____ Middle Initial: ____ First Name: _____ Maiden Name: _____
Birth Date: _____ Social Security # _____-_____-_____ Nick Name: _____

Patient Race: White/Caucasian Indian/Alaska Native Asian African American/Black
Nat Hawaiian/Pacific Islander Other Race Unknown Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Declined

Marital Status: _____ Driver's License: _____

Street Address: _____ City: _____ State: _____ Zip: _____
Billing Address (if different): _____ City: _____ State: _____ Zip: _____
Phone: (____)_____ Work: (____)_____
Cell: (____)_____ Email: _____
Relation to the patient:

Father: ___ Mother: ___ Step Father*: ___ Step Mother*: ___ Legal Guardian*: ___
Spouse: ___ Child*: ___ Foster Parent*: ___ Other*: ___

**These patient relationships all require "legal authority" in order to sign. Please ask us for a form if you do not have one.*

Additional Information

Referring Physician: _____ Telephone Number: (____)_____
Primary Care Physician: _____ Telephone Number: (____)_____
Preferred Pharmacy: _____
Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance

Policy Holder Name: _____ Policy Holder Birth Date: _____
Insurance Company Name: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Contract/ID Number: _____ Group Number: _____

Secondary Insurance

Policy Holder Name: _____ Policy Holder Birth Date: _____
Insurance Company Name: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Contract/ID Number: _____ Group Number: _____

FORMS COMPLETED BY:

Print Name: _____
Signature: _____ Date: _____
Relation if patient is a minor: _____