

## **Personal Information**

LAST FIRST Date of Birth Age SS#	Patient's Name	<u> </u>			_ Date	
o Male o Female o Single o Married o Divorced o Widowed o Partner/Significant Other Address						
Address	Date of Birth	Age	SS#			
Home Phone	o Male o Female o S	ingle o Married	d o Divorced	o Widowed	o Partner/	Significant Other
Preferred contact method? Consent to text (appointment reminders) o Yes o No Email Address  Consent to Email: o Yes o No Consent receive email notifications regarding new products/services available through our practice: o Yes o No Occupation Name of Employer	Address		City		State	Zip Code
Email Address	Home Phone	Work	,	Cell		
Consent to Email: o Yes o No  Consent receive email notifications regarding new products/services available through our practice: o Yes o No Occupation	Preferred contact method?	C	Consent to text	t (appointmen	t reminders	s) o Yes o No
Consent receive email notifications regarding new products/services available through our practice: o Yes o Not Occupation	Email Address					
Occupation	Consent to Email: o Yes o No					
In case of emergency, whom should we contact?	Consent receive email notification	s regarding nev	v products/ser	vices available	e through c	our practice: o Yes o No
Relationship to Patient Phone Number  How did you hear about us?  Pharmacy Information  Preferred Pharmacy Location Is it okay to download your medication history from your insurance company? o Yes o No  Person Responsible for Payment (if other than patient)  Name	Occupation	N	ame of Emplo	yer		
Pharmacy Information  Preferred Pharmacy Location	In case of emergency, whom shou	ıld we contact?				
Pharmacy Information Preferred Pharmacy Location	Relationship to Patient		Phor	ne Number		
Preferred Pharmacy Location	How did you hear about us?					
Is it okay to download your medication history from your insurance company? o Yes o No  Person Responsible for Payment (if other than patient)  Name	Pharmacy Information					
Person Responsible for Payment (if other than patient)  Name	Preferred Pharmacy Location					
Name	Is it okay to download your medica	ation history fro	m your insuraı	nce company	? o Yes	o No
Address         City         State         Zip Code           Home Phone         Cell         Work         Ext           Occupation         Name of Employer           Insurance Information         Primary Health Insurance Company           Policy Holder         Relationship to Patient           ID:         Date of Birth           Secondary Health Insurance Company         Relationship to Patient           Policy Holder         Relationship to Patient	Person Responsible for Payr	nent (if other t	han patient)			
Address         City         State         Zip Code           Home Phone         Cell         Work         Ext           Occupation         Name of Employer           Insurance Information         Primary Health Insurance Company           Policy Holder         Relationship to Patient           ID:         Date of Birth           Secondary Health Insurance Company         Relationship to Patient           Policy Holder         Relationship to Patient	Name	SS#				
Occupation Name of Employer Insurance Information  Primary Health Insurance Company  Policy Holder Relationship to Patient  ID: Date of Birth  Secondary Health Insurance Company  Policy Holder Relationship to Patient						
Insurance Information  Primary Health Insurance Company  Policy Holder Relationship to Patient  ID: Date of Birth  Secondary Health Insurance Company  Policy Holder Relationship to Patient	Home Phone	Cell		Work		Ext
Primary Health Insurance Company  Policy Holder Relationship to Patient  ID: Date of Birth  Secondary Health Insurance Company  Policy Holder Relationship to Patient	Occupation	N	ame of Emplo	yer		
Policy Holder Relationship to Patient  ID: Date of Birth  Secondary Health Insurance Company  Policy Holder Relationship to Patient	Insurance Information					
ID:Date of Birth  Secondary Health Insurance Company  Policy Holder Relationship to Patient	Primary Health Insurance Comp	any				
Secondary Health Insurance Company  Policy Holder Relationship to Patient	Policy Holder		Re	lationship to F	Patient	
Policy Holder Relationship to Patient	ID:	Date of	Birth			
ID:Date of Birth	Policy Holder		Rel	ationship to P	atient	
	ID:	Date	of Birth			



l,			, have receiv	ed a copy of the l	Notice of	
Privacy Practices for Peak I	ENT and Voice C	Center. By sig	ning below, I authorize	e Peak ENT and V	oice Center	
to use or disclose my medical, financial and all other personal health information for the purposes of providing						
me with treatment, collectin	g payment for the	at treatment, c	onsulting with other h	ealth care provide	rs with	
respect to my care, and disc	cussing my inforr	mation with the	eir staff to accomplish	this.		
Print Name of Patient or Le	gal Guardian					
Patient's Name						
Signature of Patient or Lega	al Guardian		Date		<u> </u>	
I authorize Peak ENT and \	oice Center to s	hare and disc	uss my information wit	th the following pe	rson:	
Name:						
Relationship: O Spouse	O Parent	O Child	O Caregiver	O Other		
At what phone number may	we leave a mes	sage if we are	not able to reach you	?		
Which means of communication	ation can we use	to remind you	ı of your appointments	s?		
O Phone	O Text	Message	O Em	ail		
For Office Use Only						
We attempted to obtain writ	ten acknowledge	ement of receip	ot of our Notice of Priv	acy Practices, bu	t this could	
not be obtained because:						
O the individual refused to s	sign O comm	nunication bar	iers restricted attainin	g the written ackn	owledgement	
O Other:						