Premier
MEDICAL GROUP

ENT Patient Information Sheet

Last Name _____ First Name _____ MI _____ DOB _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widow

Soc Sec # _____ Address _____

City _____ ST _____ ZIP _____

Home Phone _____

Employer: _____

Work Phone _____

Primary Care Doctor _____

How did you hear about Premier Medical Group? _____

Spouse Name _____ DOB _____ Soc Sec # _____ Work # _____

Emergency Contact:

Name _____ Phone # _____

Name _____ Phone # _____

COMPLETE THE FOLLOWING IF PATIENT IS A MINOR OR STUDENT

Name of person responsible for patient: _____ Relationship to Patient: _____

Mother/Legal Guardian: _____ DOB _____ Soc Sec # _____

Mother/Legal Guardian Address: _____ ST _____ ZIP _____

Mother/Legal Guardian Employer: _____ Work Phone: _____

Father/Legal Guardian: _____ DOB _____ Soc Sec # _____

Father/Legal Guardian Address: _____ ST _____ ZIP _____

Father/Legal Guardian Employer: _____ Work Phone: _____

_____

Parent or Guardian's Signature to Treat Minor Date