

Welcome To BENKE EAR NOSE & THROAT CLINIC!

***** LEGAL GUARDIANS MUST ACCOMPANY "MINORS" UNDER 18 TO RECEIVE MEDICAL CARE

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Birthdate: _____ Age: _____

Male _____ Female _____ Single _____ Married _____ Divorced _____ Widowed _____

Email Address: _____

May we send information here? Yes No

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: () _____ Cell Phone: () _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Birthdate: _____ Age: _____

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: () _____ Cell Phone: () _____

Name of Spouse: _____ Birthdate: _____ Age: _____

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Telephone: () _____ Cell Phone: () _____

In case of emergency, contact: _____ Relationship: _____

Home Phone: () _____ Work Phone: () _____

Were you referred by your primary care physician? Yes No

If yes, please list primary care physician's name _____

Which pharmacy do you use? _____

How did you learn about our practice? _____

May we contact you at work? Yes No

When is the best time to reach you? _____

