MONROE EAR, NOSE & THROAT ASSOCIATES

321 Stewart Road Monroe, MI 48162
(734) 243-5020 phone (734) 457-1970 fax

Today's Date: _______________

Patient's Name: ____________________________________ **Date of Birth**: _________________

Mailing Address: ____

City _______________________________________ Zip __________________________________

Email Address:____

Sex: M F Primary Phone ___________________________ Secondary_____________________

I permit this office to handle any voicemail communication needed on my primary or secondary number as follows:

- ☐ Permitted to leave a detailed message on voicemail
- ☐ Permitted to leave callback number only on voicemail
- ☐ I do not permit automated text

Insurance Coverage – Please provide the following information for the insurance card holder:

Name: ____ Date of Birth: _________________

Relationship to Patient: _______________________________ Phone: _______________________

Address: ____

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS PORTION:

Mother's Name:____________________ Date of Birth: _______________ Phone: ____________

Address if different from patient: ____

Father's Name:_____________________ Date of Birth: _______________ Phone: ____________

Address if different from patient: ____

- ☐ Patient is a minor; I am the patient's parent and natural guardian
- ☐ Patient is a minor; I am the patient's guardian. Please present legal documentation.
- ☐ Other (describe) ____

Preferred Pharmacy ___________________________________ **Location** ___________________

Referring Physician ____

Primary Care Physician ____