THE ENT CENTER

Lancaster Office:
810 Plaza Boulevard
Lancaster, PA 17601
Office 717-394-5088
Fax 717-394-5590

Ephrata Office:
561 W. Trout Run Road
Ephrata, PA 17522
Office: 717-733-4891
www.TheENTCenterpa.com

The ENT Center Patient Information Form

Name (Last, First, MI): _____ _____ _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

DOB: _____ Gender: _____ Race: _____ Ethnicity: _____

Marital Status: _____ SSN: _____ Preferred Language: _____

Primary Phone: _____ ☐ Home ☐ Cell ☐ Work Alternate Phone: _____ ☐ Home ☐ Cell ☐ Work

Email Address: _____

Preferred way of communication for The ENT Center: ☐ Text ☐ Email ☐ Voice ☐ Opt Out

Is Condition work related: _____ Or Result of an Accident? _____

If PATIENT is a MINOR, please complete the following: ☐ Biological ☐ Foster ☐ Legal Guardian

Mother's Name: _____ Father's Name: _____

Mother's Address: _____ Father's Address: _____

_____ _____

Mother's Phone: _____ Father's Phone: _____

Mother's DOB: _____ Father's DOB: _____

PLEASE NOTIFY OUR OFFICE IMMEDIATELY OF ANY CHANGES TO YOUR INSURANCE.

Please provide our office with your insurance card and photo identification at the time of your appointment

Primary Insurance: _____ **Secondary Insurance:** _____

Name of Policy Holder: _____ Policy Holder Name: _____

Policy Holder SSN: _____ Policy Holder SSN: _____

Policy Holder DOB: _____ Policy Holder DOB: _____

Policy Holder Employer: _____ Policy Holder Employer: _____

Identification #: _____ Identification #: _____

Group/Policy #: _____ Group/Policy #: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I request that payment of authorized Medicare/Other Insurance Company benefits be made to me or on my behalf to The ENT Center for any services rendered by The ENT Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to be determine these benefits payable to related services.

Signature: _____ Date: _____