



ENT & PLASTIC SURGERY Specialists of Louisiana

PATIENT INFORMATION & CONSENTS

DATE: _____

Name: _____ Date of Birth: _____

Gender: Male Female Other SS #: _____ Marital Status: S M D W

Address: _____
Street Address Apt # City State Zip Code

Billing Address: _____
Street Address Apt # City State Zip Code

Home #: _____ Cell #: _____ Other #: _____

Email: _____ Parent / Guardian's Name: _____

Emergency Contact: _____ Relationship: _____ Contact #: _____

May we release Personal Health Information to emergency contact? Yes No

Do you have an Advance Care Directive? Yes No *If yes, please provide us with a copy.*

Referring MD: _____ Primary MD: _____

How did you find us? MD / Hospital _____ Google Facebook Self Referral Other _____

Pharmacy: _____
Name Street City Phone Number

GOVERNMENT REQUIRED QUESTIONS

Race: White Black / African American Asian American Indian / Alaska Native
 Native Hawaiian / Other Pacific Islander Other Unreported / Declined to Report

Ethnicity: Hispanic or Latino Non Hispanic or Latino Unreported / Decline to Report

Language Preference: English Spanish Other _____

Employment Status: Employed Not Employed Retired Occupation: _____

INSURANCE INFORMATION

Patient must bring insurance card and driver's license to appointments.

If information provided below is incorrect or incomplete you will be financially responsible for all charges rendered.

Primary Insurance: _____

Secondary Insurance: _____

Member ID #: _____

Member ID #: _____

Relationship of Patient to Insured

Self Spouse Parent Other
*(Complete below if patient is **not** policy holder)*

Relationship to Patient to Insured

Self Spouse Parent Other
*(Complete below if patient is **not** policy holder)*

Name: _____

Name: _____

DOB: _____ Phone: _____

DOB: _____ Phone: _____

SS #: _____

SS #: _____

*New patient information and consent forms must be completed & returned prior to your appointment.
If unable to return in advance, patient must arrive at least 15 minutes early.*