LUFKIN ENT & ALLERGY

PATRICIA MCADAMS, M.D.
BRIAN HUMPHREYS, M.D., F.A.C.S.

PATIENT INFORMATION (Please Print Clearly)

Patient Name: ______________________ Sex (Circle One): Male Female

Preferred Name/Alias of Patient: ______________________

Date of Birth: ______________ Age: ______ Social Security #: ______________

Marital Status (Circle One): Single - Married - Divorced - Widowed - Decline

Name of Parent(s) of Minor: ______________________

Mailing Address: ______________ City: ______________ State: ____ Zip: ______

Home Phone: ______________ Cell: ______________ Work: ______________

Place of employment: ______________________

Guarantor/Family Email: ______________________

Preferred pharmacy: ______________________

Preferred hospital: ______________________

EMERGENCY CONTACT INFORMATION

Name: ______________ Relationship to patient: ______________ Phone: ______________

Name: ______________ Relationship to patient: ______________ Phone: ______________

REFERRAL INFORMATION

Referring Physician: ______________ Address: ______________

Primary Care Physician: ______________ Address: ______________

GOVERNMENT MANDATED INFORMATION

Preferred language (Circle One): English - Spanish - Decline If, Other. Please specify: ______________

Race (Circle One): White - Am. Indian - Black/African American - European - Japanese - Korean - Decline

Ethnicity (Circle One): Not Hispanic/Latino - Mexican/Hispanic/Latino - Cuban - Dominican - Puerto Rican - Decline

Contact Preference: Portal - Home Phone - Work Phone - Cell Phone - Mail

RESPONSIBLE PARTY

☐ Check if the same as patient information

Person responsible for payment: ______________ Date of Birth: ______________

Relationship to patient: ______________ SSN: ______________

Address: ______________ City: ______________ State: ____ Zip: ______

Phone: ______________ Cell: ______________

Employer: ______________ Employer Phone: ______________

Spouse name: ______________ Spouse DOB: ______________ Spouse SSN: ______________