



THE
EAR NOSE & THROAT
CENTERS OF TEXAS

Patient Name:
Date of Birth:
Street Address:
City, State, Zip Code:
Home Phone:
Cell Phone:
Primary Contact
Home or Cell

Primary Care Physician:
Referring Physician:
Sex: Male Female
Marital Status: S M D W
Social Security:
- -
Email Address:
Emergency Contact: Name, Phone Number, & Relation

Guarantor (Who is the insurance under?)

Name:
Date of Birth:
Social Security:
- -
Phone:
Relation to Patient:

Pharmacy: All prescriptions are sent electronically
Cross Streets:
Is mailing address different from guarantors address? If so, please list.

Do you have a power of attorney? If so, please list.
Authorization to discuss protected information: i.e. spouse, parents, children

**Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict or expand this listing at any time.