GREATER MILWAUKEE OTOLARYNGOLOGY, LLC

- 4600 WEST LOOMIS ROAD SUITE 201 GREENFIELD, WI 53220 TELEPHONE (414) 281-4466 FAX (414) 2814564
- 2424 S. 90th STREET SUITE 406 WEST ALLIS WI 53227 TELEPHONE (414)328-8800 FAX (414) 328-8802
- THE SURGERY CENTER 3111 W. RAWSON AVE., STE 220, FRANKLIN, WI 53132 (414) 281-4466

PATIENT INFORMATION SHEET

Welcome!

Today's Date_____

Patient's Name_____ Soc Security #_____
First MI Last

Street Address_____Apt/Lot/Unit#_____ Home Phone_____

City/State/Zip_____ Work Phone_____

May we contact you at work? Yes No (circle one) Cell Phone_____

Birthdate_____ Sex M F Marital Status S M D W

Race: ( ) American Indian/Alaskan Native ( ) Asian ( ) Black/African American ( ) White ( ) Other_____
( ) Native Hawaiian/Other Pacific Islander

Ethnicity: ( ) Hispanic or Latino/a ( ) Not Hispanic or Latino/a

Preferred Language: ( ) English ( ) Spanish ( ) Other_____

Employment Status : Employed Unemployed Retired Adult Student Status: Part Time/Full Time

Employer Name_____

Responsible Party **if patient is a minor**

Name_____ Soc Security #_____

Address if Different_____ Phone _____

Birthdate_____ Sex M F Marital Status S M D W

Relationship to Patient: Self Spouse Parent Guardian Other_____

Employer Name _____

In case of emergency notify_____ Phone_____

Name of personal physician_____ Phone_____

Doctor you wish a report of this visit sent to _____

Pharmacy Name_____ Location_____ Phone_____

Whom may we thank for referring you to us?_____

Address_____

Name of Primary Insurance Company_____

Subscriber Name_____ Soc Sec#_____ Birthdate_____

Name of Secondary Insurance Company_____

Subscriber Name_____ Soc Sec#_____ Birthdate_____

I certify that the above provided information is correct. I consent to the use or disclosure of my protected health information by Greater Milwaukee Otolaryngology, LLC. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Greater Milwaukee Otolaryngology, LLC.

SIGNED_____ **DATE**_____
Patient's or authorized person's signature

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