

Contact Information

PATIENT INFORMATION

Patient Name: _____

DOB: _____

EMERGENCY CONTACT INFORMATION

Please list two separate people with 2 different phone numbers. If the patient is a minor, list both parents and SSNs.

Emergency Contact #1 Name:

Relationship to patient: _____

Home Phone #: _____

If parent, please list SSN: _____

Cell Phone #: _____

Employer Name and Job Title: _____

Work Phone #: _____

* _____ *Initial to authorize MidKansas Ear, Nose & Throat to disclose Health Information to person listed above.*

Emergency Contact #2 Name:

Relationship to patient: _____

Home Phone #: _____

If parent, please list SSN: _____

Cell Phone #: _____

Employer Name and Job Title: _____

Work Phone #: _____

* _____ *Initial to authorize MidKansas Ear, Nose & Throat to disclose Health Information to person listed above.*

Emergency Contact #1 Name:

Relationship to patient: _____

Home Phone #: _____

If parent, please list SSN: _____

Cell Phone #: _____

Employer Name and Job Title: _____

Work Phone #: _____

* _____ *Initial to authorize MidKansas Ear, Nose & Throat to disclose Health Information to person listed above.*

I understand that I may revoke my consent to disclose health information at any time in writing. Any revocation or change will not apply to past actions. I understand this authorization will remain in effect for one year from the date it is signed unless I specify a date here: _____

Patient/Guardian Signature: _____ Date: _____