

**NORTH COUNTRY ENT, PC – ROBERT HUGHES, MD
PATIENT PROFILE**

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ () Home () Work () Cell

Phone: _____ () Home () Work () Other

Email Address: _____

Sex: () Male () Female

Date of Birth: _____ () Minor/Child

Social Security #: _____

Marital Status: () Married () Single () Divorced

Referring Physician: _____

Primary Physician: _____

Referred By: _____

PATIENT EMPLOYMENT

() Employed () Retired () Unemployed () Other

Phone: _____

Employer: _____

EMERGENCY CONTACTS

GUARANTOR (responsible for payment of account)

() Same as patient

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ () Home () Work () Cell

GUARANTOR CONTINUED

Date of Birth: _____

Social Security #: _____

Employer: _____

Address: _____

Phone: _____

PRIMARY INSURANCE

() Same as patient () Same as Guarantor () Other

Insured Party: _____

Insured Phone: _____

Company: _____

Insured ID: _____

Policy Group: _____

Relationship to Primary

Insured/Guarantor: _____

Social Security #: _____

Date of Birth: _____

SECONDARY INSURANCE

() Same as patient () Same as Guarantor () Other

Insured Party: _____

Insured Phone: _____

Company: _____

Insured ID: _____

Policy Group: _____

Relationship to Primary

Insured/Guarantor: _____

Social Security #: _____

Date of Birth: _____

PLEASE HAVE YOUR IDENTIFICATION CARD AND INSURANCE CARD(S) WITH YOU