

VICTORIA ENT Hearing Center
117 Medical Dr Ste 2 Victoria, Texas 77904-3114 361-573-4832

PATIENT NAME: _____ Appt Date: _____
FIRST MI LAST

ADDRESS _____
PO BOX/STREET CITY STATE ZIP

HOME TEL# _____ CELL #: _____

WORK # _____ SOCIAL SECURITY # _____

PREFERRED CONTACT METHOD: _____

EMAIL ADDRESS _____

BIRTHDATE: _____ AGE: _____ SEX _____ MARITAL STATUS: _____

REFERRING PHYSICIAN: _____ DOCTOR: _____

Complete this section if patient is a minor. (ADULT PRESENTING MINOR FOR TREATMENT WILL BE RESPONSIBLE PARTY ON ACCT.)

PARENT/LEGAL GUARDIAN: _____ BIRTHDATE: _____ RELATIONSHIP: _____
M/D/YR

MAILING ADDRESS: _____
PO BOX/STREET CITY STATE ZIP

HOME TEL# _____ CELL # _____

WORK # _____ SS# _____

Complete this section for the cardholder of the insurance.

POLICYHOLDER NAME: _____ SS# _____

INSURANCE: _____ DOB: _____
M/D/YR

POLICYHOLDER NAME: _____ SS# _____

INSURANCE: _____ DOB: _____
M/D/YR

EMERGENCY CONTACT/RELATIONSHIP TO PATIENT: _____
(phone numbers should not be your own)

HOME# _____ CELL# _____ Work # _____

**CMS, a federal agency within the U.S. Health & Human Services, is requesting that medical providers obtain this information.
PLEASE HELP US BY FILLING THIS OUT. THANK YOU.**

Ethnicity: ___ Decline to State ___ Hispanic or Latino ___ Not Hispanic or Latino

Race: ___ Decline to State ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ White
___ Native Hawaiian or Other Pacific Islander ___ Some Other Race

Preferred Language: ___ English ___ Spanish ___ Other, please indicate _____
Revised 07.03.17