# Albany ENT & Allergy Services

**Patient Health Care Survey**

**400 Patroon Creek Boulevard, Suite 205**
**Albany, New York 12206**
**518 701 2000**

| Patient Name | Date of Birth | Nickname (How you would like to be addressed: |
|---|---|---|
| | | |

| Street Address | City, State and Zip | Email Address |
|---|---|---|
| | | |

| Home Phone | Work Phone | Cell Phone |
|---|---|---|
| | | |

**Preferred Contact Number** ◯ Home ◯ Work ◯ Cell

**Appointment Reminders Preference** ◯ Home ◯ Work ◯ Cell ◯ SMS Text ◯ Email ◯ Opt Out

**Patient Portal**

I would like to register: ☐ Yes ☐ No If Yes go to: **https://tinyurl.com/aentpatientportal** to enroll.

**Gender** ◯ Male ◯ Female ◯ Undifferentiated Birth Gender (If different)

**Ethnicity** ◯ Non Latino- Hispanic ◯ Latino -Hispanic ◯ Decline to Specify Other

**Marital Status** ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

**Race** ◯ American Indian or Alaskan Native ◯ Afghanistan ◯ Asian ◯ African American ◯ Black or African American ◯ Iraqi ◯ More than 1 Race ◯ Native Hawaiian or Other Pacific Island ◯ White ◯ Decline to Specify Other

**Preferred Language (if other than English)**

**Are you covered by Insurance?** ☐ Yes ☐ No

**Please list all medical coverage for which you are eligible below. Use back of page if needed).**

| Primary Insurance Name | Primary Insurance Policy # | Group # | Co-Pay Office |
|---|---|---|---|
| | | | |

| Primary Insurance Policy Holder | Policy Holder Date of Birth | Relation to Patient |
|---|---|---|
| | | |

| Secondary Insurance Name | Secondary Insurance Policy # | Group # | Co-Pay Office |
|---|---|---|---|
| | | | |

| Secondary Insurance Policy Holder | Policy Holder Date of Birth | Relation to Patient |
|---|---|---|
| | | |

**Please List other Medical Providers you are seeing currently:**

| Primary Care Physician Name | PCP Phone | Provider 2 Name | Provider 2 Phone |
|---|---|---|---|
| | | | |

| Provider 3 Name | Provider 3 Phone | Provider 4 Name | Provider 4 Phone |
|---|---|---|---|
| | | | |

**Preferred Pharmacies**

| Local Pharmacy Name and Address | Mail Order Pharmacy Name |
|---|---|
| | |

**Preferred Laboratory**

◯ LabCorp ◯ Quest ◯ St. Peters Other Lab

**Were you referred to our office by:** ☐ Emergency Room ☐ Primary Care ☐ Other

**Is your visit today related to a No Fault, Worker's Compensation or Disability Injury?** ☐ Yes ☐ No

If Yes Employer

**Assignment & Release:**

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. I acknowledge that I am financially responsible for appropriate deductibles, co-payments and non-covered items, including those charges which have been denied by my insurance carrier.

**Signature of Patient or Responsible Party:** _____ **Date:** _____