LAFAYETTE OTOLARYNGOLOGY ASSOCIATES, INC.

PATIENT INFORMATION

Family Doctor _____

Patient Name _____ Marital Status _____ Sex _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Race: (circle one) Caucasian (white) Black/African American Asian Native American American Indian or Alaskan Native Other
Asian Pacific American Pacific Islander Native Hawaiian Refused

Ethnicity: (circle one) Latino Other Refused

Phone (HM) _____ Phone (WK)_____ Cell _____

e-mail address: _____

Employer _____ Employer Address _____

EMERGENCY CONTACT PERSON (someone not living with you) RELATIONSHIP _____

NAME _____ PHONE # _____

SPOUSE INFORMATION

Spouse Name _____ Sex _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Phone (HM) _____ Phone (WK)_____ Cell _____

Employer _____ Employer Address _____

COMPLETE IF UNDER 18-YEARS-OLD OR IF PARENTS CARRY INSURANCE
FATHER'S INFORMATION

Father's Name _____ Marital Status _____ Sex _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Phone (HM) _____ Phone (WK)_____ Cell _____

Employer _____ Employer Address _____

MOTHER'S INFORMATION

Mother's Name _____ Marital Status _____ Sex _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Phone (HM) _____ Phone (WK)_____ Cell _____

Employer _____ Employer Address _____

I certify the above information is correct. I agree that I will pay attorney fees and court costs incurred by my doctor in the collection of all sums due. I agree that "reasonable attorney fees" shall be interpreted as 40% of any balance due at the time the account is sent to an attorney for collection or $300.00, whichever is greater. A finance charge of 8% APR or 0.67% per month will be charged on all accounts 60 days or older.

_____ _____ _____

Signature **Date** **Witness**