

MACE L. BRINDLEY, M.D.
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Welcome To Our Office
WACO EAR, NOSE & THROAT

OTOLARYNGOLOGY
HEAD AND NECK SURGERY
NASAL ALLERGY

OFFICE USE ONLY	VERIFIED INITIALS: _____
	VERIFIED DATE: _____

FORM MUST BE COMPLETELY FILLED OUT
(Please Print)

PATIENT INFORMATION Home Ph: _____ Cell Ph: _____ Date: _____

Name: _____
Last First Middle

SS #: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Age: _____ Sex: _____ Marital Status _____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Address _____ Phone: _____
Street City State Zip

SPOUSE/GUARDIAN (please circle)

Name: _____ Relationship to Patient _____
Last First Middle

SS #: _____ / _____ / _____ Date of Birth: _____ / _____ / _____ Age: _____

Address if different from above: _____

Employer: _____ Occupation: _____

Address _____ Phone: _____
Street City State Zip

IN CASE OF AN EMERGENCY NOTIFY (not living with you - preferably local):

Name: _____ Phone: _____

Relationship to patient: _____

Allergies to Medication: _____

Referring Physician: _____ Phone: _____
(required) Last First

Address: _____
Street City State Zip

Personal Physician: _____ Phone: _____
Last First

Address: _____
Street City State Zip

Waco Ear, Nose & Throat requires payment in full of all patient responsibility balances on the date service is rendered. This includes uninsured balances, non-covered items, insured co-payments, and deductibles. Please indicate your method of payment:

Cash Check Money Order **Credit Card:** Visa Mastercard Discover

(OVER)

