

# SUMMIT ENT ASSOCIATES

## ADDITIONAL PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_ (For access to Our New Patient Portal)

### Race:

\_\_\_\_\_ American Indian or Alaska Native    \_\_\_\_\_ Black or African American    \_\_\_\_\_ Other Race  
\_\_\_\_\_ Native Hawaiian or Pacific Islander    \_\_\_\_\_ Hispanic    \_\_\_\_\_ Asian  
\_\_\_\_\_ Refused to Report    \_\_\_\_\_ White

Ethnicity: \_\_\_\_\_ Hispanic or Latin    \_\_\_\_\_ Non-Hispanic or Latino    \_\_\_\_\_ Refused to report

Language: \_\_\_\_\_ English    \_\_\_\_\_ Spanish    \_\_\_\_\_ French    \_\_\_\_\_ Japanese    \_\_\_\_\_ Chinese    \_\_\_\_\_ Other

Local Pharmacy Name: \_\_\_\_\_ Location/City: \_\_\_\_\_

MAY WE SUBMIT YOUR PRESCRIPTION ELECTRONICALLY? Y\_\_\_ N\_\_\_

Mail Order Pharmacy Name: \_\_\_\_\_

### I wish to be contacted in the following manner (check all that apply)

\_\_\_\_\_ Home Telephone: \_\_\_\_\_  
\_\_\_\_\_ O.K. to leave message with detailed information (Extended)  
\_\_\_\_\_ Leave message with call-back number only (Brief)

\_\_\_\_\_ Cell Phone: \_\_\_\_\_  
\_\_\_\_\_ O.K. to leave message with detailed information (Extended)  
\_\_\_\_\_ Leave message with call-back number only (Brief)

\_\_\_\_\_ Work Telephone: \_\_\_\_\_  
\_\_\_\_\_ O.K. to leave message with detailed information (Extended)  
\_\_\_\_\_ Leave message with call-back number only (Brief)

### AUTHORIZATION TO VIEW RX HISTORY FROM EXTERNAL SOURCE

I authorize Summit ENT Associates to view any and all available RX History from an External Source. I am aware that Summit ENT Associates uses a secure connection to SureScripts to send and receive most prescriptions in the office

\_\_\_\_\_  
(Signature of Patient, or Personal Representative)

\_\_\_\_\_  
(Relationship to Patient)

\_\_\_\_\_  
(Date)