James L. Masdon, M.D.
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Masdon ENT & Facial Plastic Surgery

602 Corley Avenue
Boaz, Alabama 35957
7938 AL HWY 69
Guntersville, Alabama 35976

Patient's Last Name:	First Name:	MI	Preferred Name:

Date of Birth / /	Age	Social Security Number - -	Sex	Marital Status ( ) Single ( ) Married ( ) Widow ( ) Other

Language	Ethnicity (Race) ( ) Caucasian ( ) Hispanic ( ) African American ( ) Other

Primary Address (Mailing Address)	City	State	Zip Code

Secondary Address (Physical Address)	City	State	Zip Code

Preferred Method of Contact ( ) Home ( ) Cell ( ) Work ( ) -	Secondary Phone Number ( ) Home ( ) Cell ( ) Work ( ) -

Employer	Employer Phone Number ( ) -

*Email Address:	How did you hear about us? ( )Doctor ( )Internet ( )Friend ( )Relative ( )Media ( )Walk-in ( )Est. Patient

EMERGENCY CONTACT *(NOT IN SAME HOUSEHOLD)*

Name:	Relationship to Patient:

Primary Phone: ( ) Home ( ) Cell ( ) Work ( ) -	Secondary Phone: ( ) Home ( ) Cell ( ) Work ( ) -

*GUARDIAN or SPOUSE INFORMATION

Name:	Address:	City:	State	Zip Code

Primary Phone ( ) Home ( ) Cell ( ) Work ( ) -	Social Security Number - -	Date of Birth / /	Relationship to Patient

Employer	Business Phone ( ) -	Email Address

Family Physician: _____ Referring Physician: _____

INSURANCE INFORMATION

Primary Insurance/ Holder Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

Secondary Insurance/ Holder Name: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

List Any Persons to Whom You Will Allow Access of Your Medical Records

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

*Were you injured on the job: ( ) Yes ( ) No Date of Injury: _____

Do you want to receive a copy of our privacy policy? Yes _____ No _____

I acknowledge that I have been offered/given a copy of Masdon ENT's privacy policy.

I certify that the **above information is true and correct** to the best of my knowledge. As the responsible party, I agree that all charges that are not directly paid by my insurance will be my responsibility.

Signature _____ Date: _____

PATIENT'S SIGNATURE **(GUARDIAN'S SIGNATURE IF PATIENT IS A MINOR)**