EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.
6802 SOUTH OLYMPIA AVE. WEST, SUITE 200 • TULSA, OKLAHOMA 74132
(918) 388-2398 • FAX (918) 388-2419
BRUCE E. HUDKINS, M.D.

DEMOGRAPHICS

LAST NAME: _____
FIRST NAME: _____
MIDDLE NAME: _____
SOCIAL SECURITY # _____
DATE OF BIRTH: _____ AGE: _____
MARTIAL STATUS: _____ SEX: _____
EMPLOYER: _____
REFERRING PHYSICIAN: _____

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
RACE: _____ LANGUAGE: _____ ETHNICITY: _____
HOME PHONE: _____ CELL PHONE: _____
E-MAIL: _____ WORK : _____
PRIMARY CARE PHYSICIAN: _____

PARENT INFORMATION (If under 18 yrs. old)

LAST NAME: _____
FIRST NAME: _____
MIDDLE NAME: _____
EMPLOYER: _____

ADDRESS: _____
RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: _____ HOME : _____
CELL PHONE: _____ WORK #: _____

PRIMARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: _____
INSURANCE CO: _____
INSURED'S DATE OF BIRTH: _____
GROUP NO. _____
POLICY EFFECTIVE DATE: _____

INSURED'S RELATIONSHIP TO PATIENT: _____
POLICY OR ID NO: _____
INSURED'S SOCIAL SECURITY NO: _____
PLAN TYPE. _____ AUTHORIZATION REQUIRED? _____
EMPLOYER: _____

SECONDARY HEALTH INSURANCE (Insured's Information)

INSURED'S NAME: _____
INSURANCE CO: _____
INSURED'S DATE OF BIRTH: _____
GROUP NO. _____
POLICY EFFECTIVE DATE: _____

INSURED'S RELATIONSHIP TO PATIENT: _____
POLICY OR ID NO: _____
INSURED'S SOCIAL SECURITY NO: _____
PLAN TYPE. _____ AUTHORIZATION REQUIRED? _____
EMPLOYER: _____

SIGNATURE: _____ DATE: _____

Confidential Communication Request

EAR, NOSE & THROAT SPECIALISTS OF TULSA, L.L.P.
6802 SOUTH OLYMPIA AVE. WEST, SUITE 200
TULSA, OKLAHOMA 74132

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communication concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I,_____(print your name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

Telephone Contact Information:

Leave message on my voice mail

❑ Do ❑ Do not

Circle: Home Work Cell

Leave message with other person

❑ Do ❑ Do not

Circle: Home Work Cell

Please list other persons that may be contacted with confidential communications

Name:_____ Relationship to patient:_____ Phone #:_____
Phone #:_____

Name:_____ Relationship to patient:_____ Phone #:_____
Phone #:_____

Signed:_____ Date:_____

Print Name:_____

If not signed by the patient, please indicate:
Relationship:
- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient
- ❑ other (specify)_____

For office use only:

Date Granted:_____ **Initials:**_____