

Allergy, Ears, Nose and Throat Associates of Texas

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PATIENT INFORMATION

Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ Male Female

Address \_\_\_\_\_  
City State Zip

Home Phone \_\_\_\_\_ Cell No \_\_\_\_\_ Message Phone \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Phone No. \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone No \_\_\_\_\_

Marital Status: Married Divorced Single Widowed

MINOR PATIENTS ONLY  
RESPONSIBLE PARTY INFORMATION

Guarantor Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ Male Female

Guarantor Employer \_\_\_\_\_ Phone No. \_\_\_\_\_

Complete below only if different than patient information above.

Address \_\_\_\_\_  
City State Zip

Home Phone \_\_\_\_\_ Cell No \_\_\_\_\_ Message Phone \_\_\_\_\_

CONTACT INFORMATION

This practice may contact me at *all* phone numbers and addresses I have listed on my patient information sheet and in my chart

This practice may contact me at *only* the following phone numbers and addresses I have listed here:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

RECEIPT OF NOTICE OF PRIVACY POLICIES

I, \_\_\_\_\_, have received and/or read a copy of Dr. Yunus' Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date