Department of Otolaryngology

Primary Care Physician_____

Address_____

Phone_____

Are there any OTHER physicians you would like a copy of today's office note sent to?

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Pharmacy Name: _____

Address: _____

Phone: _____

Do you have a Latex allergy? Yes No

Patient Signature: _____

Date: _____

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