Please fill out with black or blue ink ONLY. No Pencil.

OFFICE USE ONLY

APPOINTMENT WITH DOCTOR _____

DOCTOR ORIGINALLY REFERRED TO

_____

HOUSE EAR CLINIC, INC.

ACCOUNT REGISTRATION

OFFICE USE ONLY

ACCOUNT # _____

SCHEDULED BY _____

DATE _____

PATIENT NAME MR. MRS. MISS _____ SOCIAL SECURITY# _____
LAST FIRST INIT.

RESIDENCE ADDRESS _____
NO. AND STREET CITY STATE ZIP CODE

MAILING/TEMPORARY ADDRESS _____ DRIVER'S LIC. # _____
(IF DIFF. FROM ABOVE) NO. AND STREET CITY STATE ZIP CODE STATE

HOME TEL. # ( ) _____ TEMPORARY TEL. # ( ) _____ SEX ___ AGE _____ BIRTH DATE _____ MARITAL STATUS _____

BUS./2ND TEL. # ( ) _____ OCCUPATION (IF RETIRED, FORMER OCCUPATION) _____ EMPLOYER _____

FAX # ( ) _____ E-MAIL ADDRESS _____ CELLULAR # ( ) _____

EMPLOYER'S ADDRESS _____
NO. AND STREET CITY STATE ZIP CODE

SPOUSE'S NAME _____ SOCIAL SEC. # _____

BUS. TEL. # ( ) _____ OCCUPATION (IF RETIRED, FORMER OCCUPATION) _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____
NO. AND STREET CITY STATE ZIP CODE

WERE YOU REFERRED TO HOUSE EAR CLINIC BY PHYSICIAN YES ☐ NO ☐
IF YES, PLEASE COMPLETE:

NAME _____ IS HE/SHE AN EAR, NOSE AND THROAT SPECIALIST? YES ☐ NO ☐

ADDRESS _____ PHONE # ( ) _____

IF PATIENT IS A CHILD – GIVE NAMES OF BOTH PARENTS OR LEGAL GUARDIAN BELOW

FATHER'S NAME _____
SOCIAL SEC. # _____
OCCUPATION _____ DRIVER'S LIC. # _____
EMPLOYER _____
EMPLOYER'S ADDRESS _____
NO. AND STREET
_____ TEL. # ( ) _____
CITY, STATE, ZIP

MOTHER'S NAME _____
SOCIAL SEC. # _____
OCCUPATION _____ DRIVER'S LIC. # _____
EMPLOYER _____
EMPLOYER'S ADDRESS _____
NO. AND STREET
_____ TEL. # ( ) _____
CITY, STATE, ZIP

PLEASE COMPLETE INSURANCE INFORMATION

PRIMARY INSURANCE _____
ADDRESS _____
NO. AND STREET
_____ TEL. # ( ) _____
CITY, STATE, ZIP
SUBSCRIBER'S NAME _____
RELATIONSHIP TO SUBSCRIBER _____
CERTIFICATE NO. _____
GROUP NO. _____

SECONDARY INSURANCE _____
ADDRESS _____
NO. AND STREET
_____ TEL. # ( ) _____
CITY, STATE, ZIP
SUBSCRIBER'S NAME _____
RELATIONSHIP TO SUBSCRIBER _____
CERTIFICATE NO. _____
GROUP NO. _____

PATIENT'S SIGNATURE (X) DATE:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize the release of any medical information necessary to process any medical claim filed by House Ear Clinic, Inc. on my behalf; I also authorize payment directly to House Ear Clinic, Inc., of surgical and/or medical benefits, if any, otherwise payable to me by reason of insurance.

SIGNED (Insured person)