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 ______________________ (LAST, FIRST, INIT.) SOCIAL SECURITY# ______________________

RESIDENCE ADDRESS ______________________ (NO. AND STREET, CITY, STATE, ZIP CODE)

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

______________________ (CITY, STATE, ZIP) TEL. # (   ) ____________

MOTHER'S NAME ______________________

SOCIAL SEC. # ______________________

OCCUPATION ______________________ DRIVER'S LIC. # ______________________

EMPLOYER ______________________

EMPLOYER'S ADDRESS ______________________ (NO. AND STREET)

______________________ (CITY, STATE, ZIP) TEL. # (   ) ____________

PLEASE COMPLETE INSURANCE INFORMATION

PRIMARY INSURANCE ______________________

ADDRESS ______________________ (NO. AND STREET)

______________________ (CITY, STATE, ZIP) TEL. # (   ) ____________

SUBSCRIBER'S NAME ______________________

RELATIONSHIP TO SUBSCRIBER ______________________

CERTIFICATE NO. ______________________

GROUP NO. ______________________

SECONDARY INSURANCE ______________________

ADDRESS ______________________ (NO. AND STREET)

______________________ (CITY, STATE, ZIP) TEL. # (   ) ____________

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)