

EARS of Ardmore, Inc.

PATIENT INFORMATION

Patient's Name: _____ Phone: _____

Address: _____

Date of Birth: _____ City _____ State _____ Zip _____
Marital Status: _____ Male: _____ Female: _____

Social Security Number: _____

Patient's Employer: _____ Phone: _____

Responsible Party:

Name: _____ Phone: _____

Address: _____

Relationship to Patient: _____ City _____ State _____ Zip _____
Social Security Number: _____

Insurance Information:

Name of Insured: _____ Social Security Number: _____

Please be sure to have receptionist photocopy your insurance card for billing purposes.

Nearest Relative:(not living in same home): _____ Phone: _____

Address: _____

City _____ State _____ Zip _____

Primary/Referring Physician: _____ Phone: _____

Address: _____

City _____ State _____ Zip _____

Have we seen anyone else in your family? _____ Name: _____

I AUTHORIZE THE RELEASE OF INFORMATION TO THE APPROPRIATE MEDICAL FACILITIES, PROFESSIONAL AGENCIES, AND INSURANCE COMPANIES AS DEEMED NECESSARY. I UNDERSTAND THIS IS CONSIDERED A LEGAL DOCUMENT.

Signature

Date