

Patient Registration

Office Use – Date & Initial for Updates						

PATIENT INFORMATION

Last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	
Social Security #			Birth date: / /		Age:		Sex: <input type="checkbox"/> F <input type="checkbox"/> M
Status: Single / Married / Divorced / Separated / Widowed				E-mail address:			
Street address:					P.O. Box:		
City:			State:		ZIP Code:		
Home phone: () Please include area code		Cell Phone: () Please include area code			Work phone: () Please include area code		

Referring Physician Name, Address and Phone:

Primary Care Provider Name, Address and Phone:

If you were not referred by a Physician, How did you hear about us?
 Family / Yellow Pages / Internet / Patient / Other _____

INSURANCE INFORMATION

(Please fill out this section and give your insurance card to the receptionist.)

Is this patient covered by insurance?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Please provide Primary insurance information					
Insurance Co. Name		Subscriber's name:		SS #:	Birth date: / /
Policy ID #:			Group #:		Co-Pay \$/%
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain)					
Please provide Secondary insurance information					
Insurance co. Name:		Subscribers name:		SS #:	Birth date: / /
Policy #:		Group #:		Co-payment \$	
Patients relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain)					

Responsible party name and address:
(If patient is under 18)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone #.: Please include area code ()	Work phone #.: Please include area code ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carolina Ear and Hearing Clinic, P.C. or insurance company to release any information required to process my claims.

Patient/Resp. party signature _____ Print name _____ Date _____