



REGISTRATION FORM

Today's date:	Updated by/date:
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PATIENT INFORMATION

Last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <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 / Student		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:

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

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please provide **Primary** insurance information

Insurance co. Name	Subscriber's name:	SS #:	Birth date: / /
Group #:	Policy #:	Co-payment \$	
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 _____