Carolina Ear & Hearing Clinic, PC ★

For Ofc Use:					MR #:

Patient Name:

Address: **City:** **State:** **Zip:**	**Maiden/Other Name:** **Sex:** **Date of Birth:** **Age:** **Social Security #:**
Please check box for preferred communication: ❑ **Home #:** ❑ **Work #:** ❑ **Cell #:** ❑ **Email:**	Language: Ethnicity: ❑ Hispanic/Latino ❑ Unreported/Refused ❑ Not Hispanic/Not Latino Race: ❑ American Indian/Alaskan ❑ Other Pac Islander ❑ Asian ❑ White ❑ Black/African American ❑ More than 1 Race ❑ Native Hawaiian ❑ Unreported/Refused
Employer: Address: City: State: Zip:	
Emergency Contact: Home #: Cell #: Work #: Relationship:	**Preferred Pharmacy:** Phone #: City:
Referring Dr:	**PCP Name:**

Guarantor Information *(if different from patient)*:

Guarantor Name:	Relationship:
Address: **City:** **State:** **Zip:** **Home Phone#:** **Work Phone#:** **Cell Phone#:**	Date of Birth: Social Security #: Employer: Address: City: State: Zip:

Insurance Information

Primary Insurance Carrier:	**Secondary Insurance Carrier:**
Certificate/ID #:	**Certificate/ID #:**
Group Number:	**Group Number:**
Group Name:	Group Name:
Copay:	Copay:
Subscriber Information *(If Different From Patient)*	
Name:	Name:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:

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** **Witness/Staff Initials**