Patient Information

First Name:_________________________ MI: _____ Last Name:______________________________

Address:____

City, State and Zip code:____

Phone #'s: Home___________________ Cell__________________ Work _________________

Email Address:____

Social Security #:______________________Sex: M F Date of Birth: _______________Age______

Referred By: ____________________________Primary Care Physician:____________________________

Reason for visit:____

Responsible Party Information

Primary Insurance Co:____

Member ID:_________________________Group #:___________________***SSN*** ____________________

Policy Holder's Full name *(if not patient)*____

Patients relationship to policy holder: _____________________ ***Date of Birth*****_________________**

Secondary Insurance Co:____

Member ID:_________________________Group #:___________________SSN _____________________

Policy Holder's Full name *(if not patient)*____

Patients relationship to policy holder: _______________________ Date of Birth__________________

I hereby authorize the release of medical information to insurance carriers and/or other physicians, and also for benefits to be paid directly to Balance and Ear Center, Inc. In the care of a minor, I authorize the filing of insurance claims. I understand that I am responsible for all charges (including non-covered charges) arising for the treatment of the named patient. Should this account become delinquent, I agree to pay all collection and court costs, including attorney's fees.

Signature ____***Date***________________

In case of emergency, please notify:

Name:____ ***Phone:***____________________

If patient is a minor:

Mother's Name:____ SS#:________________________

Address:____

City, State and Zip code:____

Phone #'s: Home______________ Cell______________ Work_______________ Other__________________

Father's Name:____ SS#:________________________

Address:____

City, State and Zip code:____

Phone #'s: Home______________ Cell______________ Work_______________ Other__________________