Patient Information

First name:_____ MI: ___Last name:_____

Address:_____

City, State and Zip code:_____

Phone #'s: Home_____ Cell_____ Work_____ Other_____

Email Address:_____

Social Security #:_____Sex: M F Date of Birth: _____Age_____

Referred By: _____Primary Care Physician:_____

Occupation: _____ Employer:_____

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.

Guarantor 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_____