

The Ear Institute of Texas, P.A.

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PATIENT INFORMATION

Full Legal Name _____ Sex _____ Age _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Telephone: Home:() _____ Work:() _____ Cell:() _____

E-mail.: _____

Social Security Number _____ Marital Status: _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

How did you find us: Doctor's Referral, Phone Book, Insurance Provider List, Web-Page, Friend _____,

Other _____ *Reason for your Visit/Consultation: _____

Referring Physician's Name _____

Address _____ City _____ State _____ Zip _____

Phone Number () _____

Is your referring physician an Ear, Nose, Throat Specialist? _____ Yes _____ No

Primary Care/ Family Physician _____

Address _____ City _____ State _____ Zip _____

Phone Number () _____

INSURANCE INFORMATION (disregard if patient is same as policy holder)

Primary Insurance Company

Policy Holder _____ Policy Holder's Social Security _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

Secondary Insurance Company

Policy Holder _____ Policy Holder's Social Security _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

PERSON WHO IS THE GUARANTOR OR RESPONSIBLE PARTY FOR PATIENT'S FINANCIAL OBLIGATIONS.

*****NOT YOUR INSURANCE COMPANY*****

Full Legal Name _____ Date of Birth: _____

Social Security Number _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Employer's Phone Number () _____

Home Phone Number () _____

Alternate Phone Number () _____

IN CASE OF EMERGENCY:

Contact Person _____

Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Phone Number: Work () _____ Home () _____