REGISTRATION FORM

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ACCOUNT #:_____CHART #:_____DR._____DATE:_____

PATIENT'S NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP CODE)

BIRTHDATE:_____AGE:_____SEX:_____HOME PHONE #:_____

WORK PHONE #:_____CELL PHONE: _____SOCIAL SECURITY #:_____

EMAIL ADDRESS (PRINT): _____

DOCTOR THAT REFERRED YOU?_____ WHO IS YOUR PRIMARY CARE DOCTOR?_____

PRIMARY CARE DOCTOR'S ADDRESS: _____

MARITAL STATUS: SINGLE:_____MARRIED:_____OTHER:_____ IF STUDENT: _____ _____
(FULL TIME) (PART TIME)

EMPLOYER:_____
(NAME OF COMPANY) (ADDRESS)

WHICH PHARMACY DO YOU USE?_____

ADDRESS OF PHARMACY: _____PHARMACY PHONE #:_____
(STREET) (CITY)

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IF PATIENT IS A CHILD:
MOTHER'S NAME:_____FATHER"S NAME: _____
MOTHER'S PLACE OF EMPLOYMENT:_____WORK PHONE: _____
FATHER'S PLACE OF EMPLOYMENT:_____ WORK PHONE:_____
ARE PARENTS THE CHILD'S LEGAL GUARDIAN? _____
NAME & ADDRESS OF LEGAL GUARDIAN:_____
_____PHONE #:_____
SS#:_____ DL#:_____PRESENT EMPLOYER:_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:_____
PRIMARY CARD HOLDER'S NAME:_____RELATIONSHIP TO PATIENT:_____
ADDRESS OF CARD HOLDER:_____
(STREET) (CITY) (STATE) (ZIP CODE)
PRIMARY CARD HOLDER'S PHONE #:_____WORK PHONE #:_____
PRIMARY CARD HOLDER'S DATE OF BIRTH:_____SOCIAL SECURITY #:_____

SECONDARY INSURANCE COMPANY'S NAME::_____
PRIMARY CARD HOLDER:_____ RELATIONSHIP TO PATIENT:_____
ADDRESS OF CARD HOLDER:_____
(STREET) (CITY) (STATE) (ZIP CODE)
PRIMARY CARD HOLDER'S PHONE #:_____WORK PHONE #:_____
PRIMARY CARD HOLDER'S DATE OF BIRTH:_____SOCIAL SECURITY #:_____

If Primary Coverage is Medicare, is secondary insurance through your employer? YES:_____ NO: _____

DO YOU HAVE A THIRD PARTY HEALTH INSURANCE POLICY? YES:_____ NO: _____

SIGNED: _____DATE: _____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN & TO RELEASE INFORMATION: I hereby authorize direct payment, to my attending physician, of medical and/or surgical benefits payable for services provided. I agree to pay any balance that is not paid by insurance. I also authorize The Ear Center of Greensboro, P.A. to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payors, or others involved in processing and collection of any claims.

SIGNED:_____DATE:_____

I understand that Dr. Kraus of The Ear Center of Greensboro, P.A. shares after hours call with other Ear, Nose, and Throat physicians (Otolaryngologists-Head & Neck Surgeons) in the Greensboro Community.