

REGISTRATION FORM
The Ear Center of Greensboro, P.A.
Su Wooi Teoh, M.D., P.A.

ACCOUNT #: _____ CHART #: _____ Dr. _____ DATE: _____

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

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

BIRTHDATE: _____ AGE: _____ SEX: _____ HOME PHONE: _____
(AREA CODE) (PHONE)
WORK PHONE : _____ CELL PHONE: _____ SOCIAL SECURITY #: _____

WHICH DOCTOR ARE YOU GOING TO SEE?

WHICH DOCTOR REFERRED YOU TO US?
REFERRING DOCTOR'S ADDRESS:

MARITAL STATUS: SINGLE: _____ MARRIED: _____ OTHER: _____ IF STUDENT: _____
(FULL TIME) (PART TIME)

EMPLOYER: _____
(NAME OF COMPANY) (ADDRESS)

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 THE PARENTS THE CHILD'S LEGAL GUARDIAN?
NAME & ADDRESS OF LEGAL GUARDIAN: _____
PHONE #: _____

PATIENT INFORMATION:

SS#: _____ DRIVER'S LIC # & STATE: _____ PRESENT EMPLOYER: _____
OF YEARS EMPLOYED THERE: _____ PHONE #: _____
NAME & ADDRESS OF NEAREST RELATIVE: _____
PHONE # OF RELATIVE : _____ RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. 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 #: _____
CERTIFICATE #: _____ GROUP #: _____
PRIMARY CARD HOLDER'S EMPLOYER OR SCHOOL: _____

SECONDARY INSURANCE CO. NAME: _____
PRIMARY CARD HOLDER: _____ RELATIONSHIP TO PATIENT: _____
ADDRESS OF CARD HOLDER: _____
(STREET) (CITY) (STATE) (ZIP CODE)
PRIMARY CARD HOLDER'S HOME PHONE #: _____ WORK PHONE #: _____
PRIMARY CARD HOLDER'S DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
CERTIFICATE #: _____ GROUP #: _____
PRIMARY CARD HOLDER'S EMPLOYER OR SCHOOL: _____

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 PHYSICIAN & RELEASE INFORMATION: I hereby authorize direct payment to my attending physician(s) of medical and/or surgical benefits payable for services provided. I agree to pay any balance which is not paid by insurance. I also authorize The Ear Center of Greensboro, P.A. or Su Wooi Teoh, M.D., 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: _____

UNDERSTANDING OF CALL ARRANGEMENTS: I understand that Dr. Kraus and Dr. Teoh share after hours call with other Otolaryngologist-Head & Neck Surgeons in the Greensboro Community.

SIGNED: _____ DATE: _____