

**OTOLOGIC CENTER, INC.  
PATIENT REGISTRATION**

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. or Suite: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Male: \_\_\_\_ Female: \_\_\_\_ Marital Status: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Emergency Contact Outside of Home: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

***Ethnicity:*** White Black/African American Latino/Hispanic Decline Asian  
Native Hawaiian/Pacific Islander American Indian/Alaska Native Other

**RESPONSIBLE PARTY (If different than Policy Holder):**

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_ Apt. or Suite: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

**INSURANCE INFORMATION:** (Please bring all insurance cards, picture ID, & co-pay if applicable)

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Policy Holder SSN: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Policy Holder SSN: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_

**PHYSICIANS:** (A Primary Care Physician **MUST** be provided)

Primary Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

***How would you like to receive your appt reminder? (Please circle one and fill in below.)***

Home Call      Cell Call      Text      E-mail  
\_\_\_\_\_

**Medicare Lifetime Signature on File:**

I request payment of authorized Medicare benefits to Otologic Center Inc., for services rendered by the physicians of this company. I authorize release of medical information, as requested by my insurance, in determining applicable benefits for services rendered by the physicians of Otologic Center, Incorporated.

\_\_\_\_\_  
Signature of Patient or Responsible Party      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**Private Insurance Authorization for Assignment of Benefits/Information Release:**

I, the undersigned, authorize payment of medical benefits to Otologic Center, Inc. for services rendered by the physicians of this company. I understand that I am financially responsible for payment of all services rendered by Otologic Center, Inc. I authorize release of medical information, as requested by my insurance, in determining benefits. This information will be used for the purpose of evaluation and administering claims benefits. I understand that this office agrees to bill my insurance, as a courtesy, and that I must submit information as needed to ensure timely payment of services rendered to me.

\_\_\_\_\_  
Signature of Patient or Responsible Party      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date