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