WICHITA EAR CLINIC

Patient Information

Please Print

Last Name: _____

First Name: _____ MI: _____

Social Security Number: _____Date of Birth:_____

Sex: _____Marital Status: _____

(Check the appropriate box below)

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ More than one race

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Preferred Language: ☐ English ☐ Other (please list):_____

Patient Address: _____

City: _____State: _____Zip:_____

Email Address: _____

Referring Dr.: _____Family Dr.: _____

If patient is a child please include:

Father's Name: _____Mother's Name: _____

Responsible Party

Last Name: _____First Name: _____MI: _____

(If married please list spouse's name)_____

Address: _____

City: _____State: _____Zip: _____

Telephone Numbers

Patient:
Home Phone #: _____Mobile phone#:_____

Employer: _____Work Phone#: _____

Responsible Party:
Home Phone#: _____Mobile Phone#: _____

Employer: _____Work Phone#: _____

Insurance Information (check here if self pay) ☐

Primary Ins _____Secondary Ins_____

Primary
Please list Subscriber's information:

Last Name: _____First Name: _____MI:_____

SSN# _____ Date of Birth: _____Sex: _____

Patient Relationship to Subscriber: _____

Secondary
Please list Subscriber's information:

Last Name: _____First Name: _____MI:_____

SSN# _____ Date of Birth: _____Sex: _____

Patient Relationship to Subscriber: _____

I understand my signature requests that payment of authorized Insurance and Medicare/Medigap benefits be made to Wichita Ear Clinic and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as original.

Other Information

Are you here due to an auto accident? ☐ YES ☐ NO Date of Accident _____

Are you here due to Work Comp? ☐ YES ☐ NO Date of Injury _____

Is your insurance a health savings account? ☐ YES ☐ NO

Emergency Contact Information

Emergency Contact Name _____

Relationship to Patient _____Phone Number _____

"I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT"

Signature: _____Date: _____