The Ear Institute of Texas, P.A.

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18518 Hardy Oak, Ste. 300
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DATE: _____ CHART # _____

PATIENT INFORMATION

Full Legal Name _____ Sex _____ Age _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Telephone: Home:( ) _____ Work:( ) _____ Cell:( ) _____

E-mail.: _____ Social Security Number _____

Marital Status: _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

How did you find us: Doctor's Referral, Phone Book, Insurance Provider List, Web-Page, Friend, Other _____

Referring Physician's Name _____

Address _____ City _____ State _____ Zip _____

Phone Number ( ) _____

Is your referring physician an Ear, Nose, Throat Specialist? _____ Yes _____ No

Primary Care/ Family Physician _____ Phone Number ( ) _____

Address _____ City _____ State _____ Zip _____

Phone Number ( ) _____

INSURANCE INFORMATION (Disregard if patient is same as policy holder)

Primary Insurance Company _____

Policy Holder _____ Policy Holder's Social Security_____

Policy Holder's Date of Birth _____ Relationship to Patient _____

Secondary Insurance Company _____

Policy Holder _____ Policy Holder's Social Security_____

Policy Holder's Date of Birth _____ Relationship to Patient _____

GUARANTOR OR RESPONSIBLE PARTY FOR PATIENT'S FINANCIAL OBLIGATIONS, ***NOT YOUR INSURANCE COMPANY***

Full Legal Name _____ Date of Birth: _____

Social Security Number _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Employer's Phone Number ( ) _____ Home Phone Number ( ) _____

Alternate Phone Number ( ) _____

IN CASE OF EMERGENCY:

Contact Person _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Phone Number: Work ( ) _____ Home ( ) _____

Federal Statistical Information: Primary Language: _____ Race: _____ Ethnicity: _____