Strickland Ear Clinic

1516 W Cayuse Creek Drive, Ste 100 Meridian, ID 83646 • 208.375.HEAR (4327) • 208.965.8227 Fax

Tosha Strickland, AuD, F-AAA , CCC-A

Patient Registration Form

PRIMARY CARE/REFERRING PHYSICIAN________________________________

PATIENT NAME: First__________________ MI____ Last__________________

DATE OF BIRTH: __________________ SS#:__________________ MALE: ___ FEMALE:___

ADDRESS:________________________________

CITY/STATE:__________________ ZIP:__________________

HOME PHONE:__________________ CELL PHONE: __________________

EMAIL ADDRESS:________________________________

REFERRAL SOURCE:________________________________

OCCUPATION:______________ EMPLOYER: ______________ WK PHONE:______________

MARITAL STATUS: S/M/D/W Spouse Name:________________________________

INSURANCE:__________________ POLICY #:__________________

(Please give your insurance cards and ID to the receptionist for copies)

PARENTS OR GUARDIANS (IF MINOR)

FATHER:__________________ DATE OF BIRTH:__________________

ADDRESS: __________________ CITY:__________ STATE:________ ZIP:__________

PHONE:__________________ EMAIL: __________________

SOCIAL SECURITY #:__________________ OCCUPATION: __________________

EMPLOYER:__________________ EMPLOYER PHONE:__________________

INSURANCE:__________________ POLICY #:__________________

MOTHER:__________________ DATE OF BIRTH:__________________

ADDRESS: __________________ CITY:__________ STATE:________ ZIP:__________

PHONE:__________________ EMAIL: __________________

SOCIAL SECURITY #:__________________ OCCUPATION: __________________

EMPLOYER:__________________ EMPLOYER PHONE:__________________

INSURANCE:__________________ POLICY #:__________________

RESPONSIBLE PARTY

PLEASE COMPLETE THIS SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL:

NAME:__________________ PHONE:__________________

ADDRESS:__________________ CITY:__________ STATE:________ ZIP:__________

RELATIONSHIP TO PATIENT:________________________________

METHOD OF PAYMENT:________________________________

EMERGENCY: NAME/PHONE/RELATIONSHIP________________________________