

# Strickland Ear Clinic

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

## Patient Registration Form

PRIMARY CARE PHYSICIAN \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

PATIENT NAME: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

REFERRAL SOURCE: \_\_\_\_\_ SOCIAL SECURITY # (VA ONLY): \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WK PHONE: \_\_\_\_\_

MARITAL STATUS: S / M / D / W Spouse Name: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ POLICY #: \_\_\_\_\_  
(Please give your insurance cards to the receptionist for copies)

### PARENTS OR GUARDIANS (IF PATIENT IS A MINOR)

FATHER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL: Y N EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WK PHONE: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ POLICY #: \_\_\_\_\_

MOTHER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL: Y N EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ WK PHONE: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ POLICY #: \_\_\_\_\_

### RESPONSIBLE PARTY

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

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMERGENCY: NAME / PHONE / RELATIONSHIP \_\_\_\_\_