Strickland Ear Clinic

4689 N. Summit Way, 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_____