

SHEA EAR CLINIC REGISTRATION FORM

PLEASE PRINT & COMPLETE ENTIRE FORM

PATIENT INFORMATION

Date: _____

Patient's Name: _____
First Middle Last

Address: _____
Street City State Zip

Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widowed _____

Phone Numbers: Home # (_____) _____ Cell # (_____) _____ Fax# (_____) _____

Date of Birth: _____ SSN: _____ Email: _____

EMPLOYMENT INFORMATION:

Are you currently employed? YES / NO If yes, where _____

Occupation: _____ Work Phone #: (_____) _____

Address: _____
Street City State Zip

If retired, give last employer and occupation: _____ When did you retire? _____ Year

If disabled, who declared you disabled and for what reason? _____

SPOUSE INFORMATION:

Name: _____

Employer: _____ Work #: _____ Occupation: _____

Employer's Address: _____

ADDITIONAL INFORMATION:

Nearest Relative or Friend not living at the same address: _____ / _____
Name Relationship

Telephone #: (_____) _____ Address: _____
Street City State Zip

What is the nearest Large City & how many miles do you live from it? _____ / _____ miles

How many miles from Memphis do you live? _____ miles

OTHER DOCTOR'S INFORMATION:

REFERRED BY? _____ Address: _____

Local Ear Nose & Throat Doctor _____ Telephone #: (_____) _____

Address: _____

Local General Doctor: _____ Telephone #: (_____) _____

Address: _____

List any additional Doctors that have treated you for your present illness (if you need additional space use the back):

Name Address City State Zip Phone #

SHEA EAR CLINIC REGISTRATION FORM (Cont'd)

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INSURANCE INFORMATION:

Primary Insurance: _____

Does Insurance Require a Referral? YES / NO

If Policyholder is not the Patient please complete this information below.

Policyholder's Name: _____

Patient's Relationship to Policyholder: _____

Policyholder's SS #: _____

Policyholder's Date of Birth: _____

Secondary Insurance: _____

Does Insurance Require a Referral? YES / NO

If Policyholder is not the Patient please complete this information below.

Policyholder's Name: _____

Patient's Relationship to Policyholder: _____

Policyholder's SS #: _____

Policyholder's Date of Birth: _____

I agree that I am personally responsible for all charges incurred in behalf of the above name patient. I also understand that these charges are due and payable by me on the same day services are rendered, also that an approximate estimate of charges for this day's office visit was explained to me at the time the appointment was made.

I also agree if, for any reason, it is necessary to refer this account to any agency for collection, I will pay all cost incurred in the collection of this account including attorney's fees.

Guarantor's Signature _____ Relationship to Patient _____ Date _____

Witness's Signature: _____