PATIENT INFORMATION

DeSoto EYE & EAR

Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F
MM / DD / YYYY

Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Occupation: _____

Place of Employment: _____ Work Phone: _____

INSURANCE INFORMATION

Policy Holder

Name: _____
First *Middle* *Last*

Date of birth: _____ Relationship to Patient: _____
DD/MM/YYYY

Primary Insurance

Insurance Carrier: _____
Name *Address* *Phone Number*

Policy Number _____ Group Number _____

Secondary Insurance

Insurance Carrier _____
Name *Address* *Phone Number*

Policy Number _____ Group Number _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Please Check here to request your records from this medical office to be sent to your Primary Care Physician YES☐ NO☐

REFERRED BY We like to know how our patients find our practice. Please check the MOST influential sources of information about this practice.

☐ Physician ☐ Audiologist ☐ Health Plan ☐ Health Fair ☐ Internet

☐ Family _____ ☐ Friend _____ ☐Other _____

IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM FOR YOU, THE FOLLOWING MUST BE SIGNED

I authorize the release of any medical and/or other information necessary to process my medical claim. Further, I authorize payment of medical benefits to be made directly to DeSoto EYE & EAR, LLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____
Patient/Parent/Guardian Signature *Date*

I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices. _____
Initials