EAR INSTITUTE OF CHICAGO, LLC

Patient Information--*PLEASE COMPLETE THE ENTIRE FORM*

Last Name:			Home Phone:		Work Phone:
First Name:		MI:	Address:		
Age:	**DOB:**	**Sex:**	City:	State:	Zip:
SSN:			Cell phone:		
Email Address:			Allergies:		
Marital Status:		Reason for your visit:			
Referring physician:			Phone:		
Address:					
Primary physician:			Phone:		
Address:					
Insurance Information:		Insurance Company Name:			
Insurance holder name:			**Insurance holder SSN:**		
Insurance holder DOB:		Home phone:		Work Phone:	
Copay Amount:		Address:		State:	Zip Code:
Group #:		Policy #:		Plan #:	
Is this plan through an employer?:			Employers Name:		
Secondary Insurance Company:		Name of Company:			
Insurance holder name:			**Insurance holder SSN:**		
Insurance holder DOB:		Home phone:		Work Phone:	
Copay Amount:		Address:		State:	Zip Code:
Group #:		Policy #:		Plan #:	
Is this plan through an employer?:			Employers Name:		
Guarantor: Person financially responsible to pay account balance after insurance					
Name:			Address:		
Phone:			City:	State:	Zip Code:
Emergency Contact:		Name:		Relationship:	
Home Phone:			Work Phone:		

Cancellation/No Show Policy *: Because our time is as valuable as yours, if you fail to show up for your scheduled appointment and do not call to cancel, there will be a $50 charge made to your account. If you schedule and cancel an appointment two consecutive times, you will incur a similar charge of $50.*

Signature:_____Date:_____ *(or representative)*

Phone Messages:
May we leave a phone message at home?_____
at work? _____
Name of persons authorized to speak about patient's results/condition

_____