Clear Form

INFORMATION FOR CASE HISTORY

Patient's Name (First Middle Last) Date of Birth

Married Unmarried Widowed Age Male Female

Home Address City Zip Code

Home Phone Cell Phone Social Security #

Email Address

Employer Phone

Address City Occupation

Name of spouse (parent or guardian if minor)

Referred By

Emergency contact Phone

What is your main complaint?

Do you have any of the following?

Yes	No		Yes	No		Yes	No	
		Earaches			Dizziness			Difficulty with nasal breathing
		Ear drainage			Hoarseness			Sore throat
		Difficulty hearing			Coughing			Allergies - Specify
		Sinus problems			Sore glands			Drug Reactions – Specify

If patient is less than age 18, a parent or guardian must sign below to authorize treatment.

Signature of parent or guardian

INSURANCE INFORMATION

Primary Insurance

Insurance company Phone

Insured Name

Insured ID #

Group Name or #

Patient Relationship to Insured Self Spouse Child Other

Secondary Insurance

Insurance Company Phone

Insured Name

Insured ID#

Group Name or #

Patient Relationship to Insured Self Spouse Child Other

STATEMENT TO PERMIT PAYMENT OF INSURANCE BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ALAN FISHER, MD AND/OR HEARMD, INC. FOR ALL INSURANCE BENEFITS DUE FOR SERVICES FURNISHED. I AUTHORIZE ALAN FISHER, MD AND/OR HEAR MD, INC. TO RELEASE THE INFORMATION REQUIRED TO RECEIVE PAYMENT OF BENEFITS.

I UNDERSTAND THAT SOME SERVICES RENDERED BY THIS OFFICE ARE NOT COVERED BY INSURANCE BENEFITS. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL THOSE INCURRED CHARGES.

SIGNATURE DATE