OFFICE USE ONLY		OFFICE USE ONLY
APPOINTMENT WITH DOCTOR _____	**Jackson Ear Clinic, P.A.**	ACCOUNT # _____
ON _____	St. Dominic West Tower	RECORDED BY _____
DOCTOR ORIGINALLY REFERRED TO _____	971 Lakeland Drive, Suite 854	DATE _____
	Jackson, Mississippi 39216	

PATIENT NAME MR. MRS. MISS _____ (FIRST / INT / LAST) SOCIAL SECURITY # _____

MAILING ADDRESS _____ (NO AND STREET / CITY / STATE / ZIP CODE)

E-MAIL ADDRESS _____ DRIVER'S LIC. # _____ (STATE)

HOME TEL # (A/C) _____ CELL # (A/C) _____ SEX ___ AGE ___ BIRTH DATE _____ MARITAL STATUS _____

BUS./2ND TEL. # (A/C) _____ OCCUPATION (IF RETIRED, FORMER OCCUPATION) _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ (NO AND STREET / CITY / STATE / ZIP CODE)

SPOUSE'S NAME _____ DOB _____ SOCIAL SEC. # _____

BUS. TEL. # (A/C) _____ OCCUPATION (IF RETIRED, FORMER OCCUPATION) _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ (NO AND STREET / CITY / STATE / ZIP CODE)

IF PATIENT IS CHILD - GIVE NAMES OF BOTH PARENTS OR LEGAL GUARDIAN BELOW

FATHER'S NAME _____
SOCIAL SEC. # _____ DOB _____
ADDRESS _____
EMPLOYER _____
EMPLOYER'S ADDRESS _____ (NO. AND STREET)
_____ TEL: ( ) _____ (CITY, STATE, ZIP)

MOTHER'S NAME _____
SOCIAL SEC. # _____ DOB _____
ADDRESS _____
EMPLOYER _____
EMPLOYER'S ADDRESS _____ (NO. AND STREET)
_____ TEL: ( ) _____ (CITY, STATE, ZIP)

NEXT OF KIN

NAME _____
ADDRESS _____ (NO AND STREET)
_____ TEL.# ( ) _____ (CITY, STATE, ZIP / A/C)
RELATIONSHIP: SON____ DAUGHTER____ OTHER____

HAS DIZZINESS BEEN A PROBLEM? YES ☐ NO ☐
WHO REFERRED YOU TO US? _____
IF PERSON ABOVE IS A DOCTOR IS HE/SHE AN EAR, NOSE, THROAT SPECIALIST? YES ☐ NO ☐
ADDRESS _____ (NO AND STREET)
_____ TEL. # ( ) _____ (CITY, STATE, ZIP / A/C)

INSURANCE INFORMATION — PLEASE COMPLETE

PRIMARY INSURANCE _____
ADDRESS _____ (NO. AND STREET)
_____ TEL. # ( ) _____ (CITY, STATE, ZIP / A/C)
SUBSCRIBER'S NAME _____
RELATIONSHIP TO SUBSCRIBER _____
CERTIFICATE NO. _____
GROUP NO. _____

SECONDARY INSURANCE _____
ADDRESS _____ (NO. AND STREET)
_____ TEL. # ( ) _____ (CITY, STATE, ZIP / A/C)
SUBSCRIBER'S NAME _____
RELATIONSHIP TO SUBSCRIBER _____
CERTIFICATE NO. _____
GROUP NO. _____

(X) _____ DATE: _____
PATIENT'S SIGNATURE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:
I hereby authorize the release of any medical information necessary to process any medical claim filed by Jackson Ear Clinic, P.A. **on my behalf;** I also authorize payment directly to Jackson Ear Clinic, P.A. of surgical and/or medical benefits, if any, otherwise payable to me by reason of insurance.

SIGNED (Insured Person)

JEC-003

PLEASE COMPLETE OTHER SIDE