

OFFICE USE ONLY	
APPOINTMENT WITH DOCTOR _____	
ON _____	
DOCTOR ORIGINALLY REFERRED TO _____	

Jackson Ear Clinic, P.A.
 St. Dominic West Tower
 971 Lakeland Drive, Suite 854
 Jackson, Mississippi 39216

OFFICE USE ONLY	
ACCOUNT # _____	
RECORDED BY _____	
DATE _____	

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

MAILING ADDRESS _____
NO AND STREET CITY STATE ZIP CODE

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

HOME TEL # (AVC) _____ CELL # (AVC) _____ SEX _____ AGE _____ BIRTH DATE _____ MARITAL STATUS _____

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

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

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

BUS. TEL. # (AVC) _____ OCCUPATION _____ EMPLOYER _____
(IF RETIRED, FORMER OCCUPATION)

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'S ADDRESS _____
NO AND STREET CITY, STATE, ZIP TEL: ()

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

NEXT OF KIN

NAME _____ ADDRESS _____
NO AND STREET CITY, STATE, ZIP TEL. # ()
 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 CITY, STATE, ZIP TEL. # ()

INSURANCE INFORMATION — PLEASE COMPLETE

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

SECONDARY INSURANCE _____ ADDRESS _____
NO AND STREET CITY, STATE, ZIP TEL. # ()
 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)