UTAH EAR INSTITUTE
HEARING-BALANCE-TINNITUS

# Patient Registration Form

Patient's Name: _____ Soc. Sec. #: _____-_____-_____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Spouse or Relative: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Dr. Phone #: _____

Primary Care Physician: _____ Dr. Phone #: _____

Primary Insurance: _____ Policy Holder: _____ Date of Birth: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder: _____ Date of Birth: _____

Policy #: _____ Group #: _____

**For patients under 18 years of age**

Responsible Party: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

How did you hear about us?

☐ Friend: _____ ☐ Doctor: _____

☐ Newspaper ☐ Mail ☐ Phonebook ☐ Seminar ☐ Website ☐ Other: _____

**Please Initial**

_____ I certify this information is true and correct to the best of my knowledge, and I hereby consent to treatment by the providers of Utah Ear Institute. I understand that diagnostic testing done will be billed to my insurance I have read the terms and conditions of the Billing Agreement and the Notice of Privacy Practices, and hereby agree to abide to all terms and conditions as outlined. I hereby authorize the release of all pertinent information including diagnosis, examination records and treatment records to authorized persons. These records will be held in strict confidence and are not available to unauthorized persons. Utah Ear Institute may use my home address and/or e-mail adderss to communicate current and future technology updates and offers related to my treatment.

_____ I understand that Cerumen (wax) removal from the ear canal is not eligible for reimbursement by my insurance. There is a $25 charge per ear for minimal/marginal wax levels, a $50 charge per ear for severe wax levels and a $100 charge per ear for significantly compacted wax levels.

Signed: _____ Date: _____