PATIENT INFORMATION Michigan Ear Institute (PLEASE PRINT)

Full Legal Name office use ______

____ Sex M F

First Middle Initial Last Marital Status S M W D

Address____ Birthdate______________________

____ Soc. Sec. #____________________

City State Zip

Home Phone (______)____________________________ Work Phone/Cell Phone (_____)____________________

Emergency Number(______)__________________________ E-mail(optional)______________________________

INSURANCE INFORMATION (*please provide cards*) **Is this an accident or work related injury?** Y N

•Primary Insurance Company____ Is this an HMO? Y N

Subscriber Name (if different than patient)__________________________ Relationship to patient______________________

Subscriber date of birth____________________________ Subscriber SS#________________________________

Subscriber Employer____Employer phone #______________________________

•Secondary Insurance Company (if any)____Is this an HMO? Y N

Secondary Subscriber Name____Relationship to patient______________________

Subscriber date of birth_________________________ Subscriber SS#________________________________

Subscriber Employer____Employer phone #______________________________

Referring Physician Name____Phone__________________________

Address____

Street City State Zip

Primary Care Physician – Family Doctor (MUST HAVE FOR HMO INSURANCE)

Physician Name____Phone________________________________

Address____

Street City State Zip

If you need to keep additional physicians updated on your visits, please provide the information on the back. A letter will be sent to your physician(s) from your MEI physician with updates UNLESS you specify that you DO NOT want one sent.

• I, the undersigned, do acknowledge that the information stated above is true. I authorize the Michigan Ear Institute to release medical information necessary to process my insurance claims. I authorize payments for medical benefits directly to the Michigan Ear Institute. For insurance purposes, I permit a copy of this authorization to be used in place of the original. I do hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered, or those to be rendered to me or to my dependents by the Michigan Ear Institute, regardless of my insurance coverage, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 10%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due. I understand that there will be a $35 charge for any returned checks. I also authorize the Michigan Ear Institute to release medical information to the above stated physicians. I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician.

SIGNATURE OF PATIENT/LEGAL GUARDIAN__________________________________**DATE**_______________

(Valid for one year)

Relationship to patient: _________________

Physician Name ________________________________

Address____

____
City State Zip

Physician Name__________________________________

Address____

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City State Zip