James V. Crawford, MD
Eric P. Wilkinson, MD

IDAHO EAR CLINIC

Michael Bateman, AuD
Adam Reyes, AuD
Shane Hunsaker, AuD

PATIENT INFORMATION

(Please print legibly)

PHYSICIAN_____DATE_____

HOW DID YOU HEAR ABOUT US _____

Patient Name: (Last)_____(First)_____(Middle)_____

Social Security #_____Driver's License #_____State_____

Date of Birth_____Age_Sex: M____F____ Marital Status: S____M____ D____W ____

Address_____City_____State_____ZIP_____

Mailing Address_____City_____State_____ZIP_____

Phone Number_____Cell Phone_____Email Address _____

PREFERRED METHOD OF CONTACT ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Fax ☐ Patient Portal/Secure E-Mail

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RACE	☐ African American	☐ Asian	☐ Hispanic	☐ Caucasian	☐ Filipino	ETHNICITY	☐ Hispanic
	☐ Native American		☐ Native Hawaiian	☐ Pacific Islander	☐ Other		☐ Non-Hispanic

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Emergency Contact (other than home)_____Phone_____

Address_____City_____ State_____ZIP _____

Relationship_____

Employer_____Occupation_____Phone_____ext._____

Address_____City_____State_____ZIP _____

INSURANCE

Primary_____

Name of Insured_____

SS#_____

Date of Birth _____

Relationship: Self____ Spouse_____ Child_____ Other

ID# _____

Group Name_____

Group #_____

Secondary_____

Name of Insured_____

SS#_____

Date of Birth _____

Relationship: Self____ Spouse_____ Child_____ Other

ID# _____

Group Name_____

Group #_____

13900 W. Wainwright Dr., Ste. 102, Boise, ID 83713
Ph: (208) 938-5823 – Fax: (208) 938-5306

459 Locust St. N, Ste. 110, Twin Falls, ID 83301 / 2311 Parke Ave., Ste. 3, Burley, ID 83318
Ph: (208) 734-8263 – Fax: (208) 734-8481

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IF PATIENT IS A MINOR OR A STUDENT

School Name_____ Address_____ Phone_____
Father's Name_____ Date of Birth_____ SS#_____ Address_____
_____ City_____ State_____ ZIP_____
Employer_____ Work Phone_____ Ext._____
Mother's Name_____ Date of Birth_____ SS#_____
Address_____ City_____ State_____ ZIP_____
Employer_____ Work Phone_____ Ext._____

JOB RELATED / AUTO INJURY INFORMATION

Please advise, per practice policy, we <u>DO NOT</u> accept payment through attorneys, liens, liability carriers or any third-party entities. If this is a Workman's Compensation case, please complete the section below in its entirety.

Is injury related to: ☐ Auto Accident ☐ Job Related

Employer_____ Phone No_____ Fax_____

Address_____ City_____ State_____ Zip_____

If injury is job-related, is this the employer you were working for at the time of injury? ☐ Yes ☐ No

Date of injury:_____/_____/_____

Related symptoms:_____

Claim #_____ Case Manager: _____

Phone No.:_____ Fax: _____

REFERRAL INFORMATION

Primary Care Physician_____ Referring Physician _____

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Idaho Ear Clinic contracts with many insurance companies, it is my responsibility to verify with my plan that Idaho Ear Clinic is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Idaho Ear Clinic will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If, however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Idaho Ear Clinic to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines.

Patient Signature_____ _____ _____
Parent/Legal Authorized Representative Relationship to Patient Date

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