IDAHO EAR CLINIC

New Patient Paperwork - Minor

Patient Information

Name (First, Middle, Last)	Birth Date	Age	Social Security #

Birth Sex ☐ M ☐ F	Primary Care Provider ☐ None

Mailing Address	Apt. #	City	State	Zip

Email Address	Home Phone	Cell Phone

Employer	Work Phone

Preferred Language	RACE ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African ☐ Native Hawaiian or Other Pacific ☐ White
ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino	

EMERGENCY CONTACT	Name	Relationship	Primary Phone

Mother Information			Father Information		
DOB	Social Security No.		DOB	Social Security No.	
Address			Address		
City	State	Zip	City	State	Zip
Home Phone No.	Cell Phone No.		Home Phone No.	Cell Phone No.	

Preferred Pharmacy

Pharmacy Name	Pharmacy Location & Phone No.

Insurance | Please present your ID and insurance card to the receptionist.

PRIMARY INSURANCE CARRIER			SECONDARY INSURANCE CARRIER		
Insurance Company Name			Insurance Company Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Policy Number		Phone	Policy Number	
Group Number / Name			Group Number / Name		
Insured Name & DOB			Insured Name & DOB		

☐ ☐ Spouse ☐ Dependent ☐ Self ☐ ☐ Dependent