California Ear Institute California Sinus Institute California Face and Laser Institute Let Them Hear Foundation

Today's Date

Patient Information

Name______________________________ Date of Birth__________ Age______
last name   first name   m.i.

Address____
street   apt #   city   state   zip

Mailing Address____
If different than above   city   state   zip

Home Phone (   ) ____________________   Sex: M F   Status: S M D W

Additional Information for **PATIENT** or Guardian (Required)

Name of responsible person if other than patient or if patient is a minor ____________________

Relationship to Patient ____________________ Date of Birth__________

Home Phone (   ) ____________________   **Work Phone** (   ) ____________________

Cell Phone (   ) ____________________   **E-Mail** ____________________

Social Security #____________________   **Driver's License #/State** ____________________

Place of Birth ____________________   **Occupation** ____________________

Emergency Contact Information

Name of Person to Contact ____

Phone (   ) ____________________   Relationship to Patient ____________________

☐ Check here to authorize CEI / CSI / CFI / LTHF to disclose your private health information to this individual

Insurance Information

Primary Insurance (Courtesy only for LTHF)

Insurance Co. Name____________________

Subscriber Name____________________

Subscriber I.D. #____________________

Group or Policy #____________________

Subscriber Date of Birth____________________

Relationship to Patient____________________

Secondary Insurance (Courtesy only, all Clinics)

Insurance Co. Name____________________

Subscriber Name____________________

Subscriber I.D. #____________________

Group or Policy #____________________

Subscriber Date of Birth____________________

Relationship to Patient____________________

How Did You Hear About Us?

Reason for Consultation ____

Referred By ____________________   Specialty ____________________

Address ____________________   Phone (   ) ____________

Or ☐ Yellow Pages ☐ Relative ☐ Friend ☐ Employee ☐ Event ☐ Other____________________

Who is your Primary Care Physician? ____________________

Address ____________________   Phone (   ) ____________

Other

I would like to receive information about Let Them Hear Foundation and other CEI related activities   e-mail address____________________   ☐ Yes   ☐ No

CEI / CSI / CFI / LTHF may leave voice mail messages containing my private health Information on any of the phone numbers listed on this form   ☐ Yes   ☐ No

Language I would prefer reminder phone calls in ____________________