

**REGISTRATION FORM**

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ACCOUNT #: \_\_\_\_\_ CHART #: \_\_\_\_\_ DR. \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP CODE)

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HOME PHONE #: \_\_\_\_\_

WORK PHONE #: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

EMAIL ADDRESS (PRINT): \_\_\_\_\_

WHICH DOCTOR/AUDIOLOGIST ARE YOU GOING TO SEE? \_\_\_\_\_

WHICH DOCTOR REFERRED YOU TO US? \_\_\_\_\_ ADDRESS: \_\_\_\_\_

MARITAL STATUS: SINGLE: \_\_\_\_\_ MARRIED: \_\_\_\_\_ OTHER: \_\_\_\_\_ IF STUDENT: \_\_\_\_\_  
(FULL TIME) (PART TIME)

EMPLOYER: \_\_\_\_\_  
(NAME OF COMPANY) (ADDRESS)

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**IF PATIENT IS A CHILD:**

MOTHER'S NAME: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_

MOTHER'S PLACE OF EMPLOYMENT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

FATHER'S PLACE OF EMPLOYMENT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

ARE PARENTS THE CHILD'S LEGAL GUARDIAN? \_\_\_\_\_

NAME & ADDRESS OF LEGAL GUARDIAN: \_\_\_\_\_

PHONE #: \_\_\_\_\_

SS#: \_\_\_\_\_ DL#: \_\_\_\_\_ PRESENT EMPLOYER: \_\_\_\_\_

# OF YEARS EMPLOYED THERE: \_\_\_\_\_ PHONE #: \_\_\_\_\_

NAME & ADDRESS OF NEAREST RELATIVE: \_\_\_\_\_

PHONE #: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

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**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

PRIMARY CARD HOLDER'S NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS OF CARD HOLDER: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP CODE)

PRIMARY CARD HOLDER'S PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

PRIMARY CARD HOLDER'S DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

CERTIFICATE #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

PRIMARY CARD HOLDER'S EMPLOYER OR SCHOOL: \_\_\_\_\_

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SECONDARY INSURANCE COMPANY'S NAME: \_\_\_\_\_

PRIMARY CARD HOLDER: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS OF CARD HOLDER: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP CODE)

PRIMARY CARD HOLDER'S PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

PRIMARY CARD HOLDER'S DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

CERTIFICATE #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

PRIMARY CARD HOLDER'S EMPLOYER OR SCHOOL: \_\_\_\_\_

**If Primary Coverage is Medicare, is secondary insurance through your employer?** YES: \_\_\_\_\_ NO: \_\_\_\_\_

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DO YOU HAVE A THIRD PARTY HEALTH INSURANCE POLICY? YES: \_\_\_\_\_ NO: \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN & TO RELEASE INFORMATION:** I hereby authorize direct payment, to my attending physician, of medical and/or surgical benefits payable for services provided. I agree to pay any balance that is not paid by insurance. I also authorize The Ear Center of Greensboro, P.A. to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payors, or others involved in processing and collection of any claims.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

I understand that Dr. Kraus of The Ear Center of Greensboro, P.A. shares after hours call with other Ear, Nose, and Throat physicians (Otolaryngologists-Head & Neck Surgeons) in the Greensboro Community.