Ear Institute of Chicago/AMITA Health Registration Form •• 11 Salt Creek Ln. Hinsdale IL 60521

Please review and update the information below to the best of your ability

Patient Registration

CURRENT PATIENT INFORMATION : PRINT OR TYPE	**Guarantor Information (to whom statements are sent)**
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient:
City:	Date of Birth:
State: Zip:	Soc Sec No:
Home Phone:	Phone:
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex: Date of Birth:	Relationship:
Soc Sec No:	Phone:
Email:	Mobile Phone:
Required by government (although you may refuse)	**Employer Information**
Language:	Employer:
Race:	Address:
Ethnicity:	Phone:
Marital Status:	

Other	**Pharmacy Information**
Patient Referred by:	Name:
Primary Care Provider:	Address:
Contact preference (Circle all that apply): Home Phone / Work Phone / Mobile Phone / Portal	Phone:
Primary Insurance Information	**Secondary Insurance Information**
Plan Name:	Plan Name:
Last Name:	Last Name:
Middle Name:	Middle Name:
Address:	Address:
City/State/Zip	City/State/Zip
Date of Birth: Sex:	Date of Birth: Sex:
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed:_____ Date: _____