

OKLAHOMA EAR CLINIC & HEARING CENTER REGISTRATION

Jack E. Metcalf, M.D.

Date _____ Please Print

Patients Name _____ Sex: M F

Date of Birth _____ - _____ - _____ Age: _____ SSN: _____

Marital Status (Circle one) M S D W Race: _____

Patients Address: _____

City: _____ ST _____ Zip _____

Home Ph: (_____) _____ Work Ph: _____ Cell/Pgr: _____

Referring Physician: _____ Phone: (_____) _____

Employer: _____ Occupation: _____

Work Address: _____

City: _____ ST: _____ Zip: _____

Spouse Name: _____ SSN: _____

Date of Birth: _____ - _____ - _____ Work Ph: _____

Spouse Employer: _____ Occupation: _____

Work Address: _____ City/ST/Zip: _____

Emergency Contact _____ Phone: (_____) _____

(Outside of Home)

Do you have Insurance? (check One) Yes _____ No _____ ***Please Present insurance card to Receptionist***

Name of Primary Insurance: _____ Secondary: _____

Policy Holder Name _____ Policy Holder Name _____

Answer the following if patient is under the age of 21

Mother's Name: _____ SSN: _____

Mother's DOB: _____ - _____ - _____ Work Phone: _____

Employer: _____ Occupation: _____ Address: _____

Father's Name: _____ SSN: _____

Father's DOB: _____ - _____ - _____ Work Phone: _____

Employer: _____ Occupation: _____ Address: _____

Authorization for services/ Please read the following and sign at the bottom of this form

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am

Responsible for any portion of my bill not covered by my insurance company, whether a co-pay, co-insurance,

Deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also

Understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices. You may read &/or download information on this web site or request a copy when you are in the office.

This Acknowledges I have Received the Notice of Privacy Practices from my Provider.

Signature: _____ Date: _____