Fax: 410-964-5249

Phone: 410-964-5226

Earl V. Wilkinson, M.D., FACS, LLC

Fellow of the American Academy of Otolaryngology Head and Neck Surgery

Ear, Nose, Throat & Sinus Disorders

Allergy & Licensed Acupuncture

5500 Knoll North Drive, Suite 310, Columbia, MD 21045

www.ENT-Physician.com

REGISTRATION (please print)

Type in information now and print OR print and fill out form

Date

Required Patient Information (The Patient is 18 years and above)

Last Name

First Name

Middle Name

Street Address

Street Address

City State Zip Code

Home Phone Work Phone Ext. # Cell Phone

D.O.B Sex: SSN Marital Status

Patient Employment Status Occupation

Name of Employer

Employer Address

It is possible that a patient may need to have a prescription filled. Supplying information about the patient's pharmacy may allow prescriptions to be electronically sent to the pharmacy before leaving the medical practice of Earl V. Wilkinson, MD, LLC

Pharmacy Name

Street Address

Street Address

City State Zip Code

Pharmacy Phone Pharmacy Fax

Patient's EMAIL Address

The patient must supply federally issued photo ID with a current address, such as a driver's license or passport. If the federally issued photo ID does not have a current address please supply copies of two reoccurring bills, such as a telephone bill or a gas/electric/water bill that has the correct current address

Whom may we thank for referring you?

- ☐ Please check here if your Primary Care Physician referred you to see Earl V. Wilkinson, M.D. or an ENT physician in general
- ☐ Please check here if your Primary Care Physician is aware of the problem you are having today or history of this problem or condition

How'd you find us?

Please provide us with information of how to contact your Doctor

Primary Care Physician(PCP)

PCP's Street Address

PCP's Street Address

City State Zip Code

PCP Phone

PCP Fax

Required co-payments to see a specialist are required at the time of service

Payments must be made with cash or check only.

Credit cards are not accepted by the practice for payment of services

REGISTRATION (please print) Earl V. Wilkinson, M.D., FACS, LLC

Type in information now and print OR print and fill out form Date

First or Primary Insurance Information

Insurance Company Name

Subscriber # /Member #/ Policy #

Group#

insurance Policy Guarantor's Last Name

insurance Policy Guarantor's First Name

insurance Policy Guarantor's Middle Name

Guarantor's Street Address

Guarantor's Street Address

City State Zip Code

Home Phone Cell Phone

D.O.B Sex: SSN Relationship to Insured

Guarantor Employment Status Occupation

Name of Employer

Employer's Street Address

Employer's Street Address

City State Zip Code

Work Phone Work Extension

Names of other dependents covered under this plan

Second or Secondary Insurance Information

Insurance Company Name

Subscriber # /Member #/ Policy #

Group#

insurance Policy Guarantor's Last Name

insurance Policy Guarantor's First Name

insurance Policy Guarantor's Middle Name

Guarantor's Street Address

Guarantor's Street Address

City State Zip Code

Home Phone Cell Phone

D.O.B Sex: SSN Relationship to Insured

Guarantor Employment Status Occupation

Name of Employer

Employer's Street Address

Employer's Street Address

City State Zip Code

Work Phone Work Extension

Names of other dependents covered under this plan

REGISTRATION (please print) Earl V. Wilkinson, M.D., FACS, LLC

Type in information now and print OR print and fill out form Date

Third or Tertiary Insurance Information

Insurance Company Name

Subscriber # /Member #/ Policy #

Group#

insurance Policy Guarantor's Last Name

insurance Policy Guarantor's First Name

insurance Policy Guarantor's Middle Name

Guarantor's Street Address

Guarantor's Street Address

City State Zip Code

Home Phone Cell Phone

D.O.B Sex: SSN Relationship to Insured

Guarantor Employment Status Occupation

Name of Employer

Employer's Street Address

Employer's Street Address

City State Zip Code

Work Phone Work Extension

Names of other dependents covered under this plan

Primary Emergency Contact Relationship to Patient

Patient's Primary Emergency Contact

Primary Emergency Contact Last Name

Primary Emergency Contact First Name

Primary Emergency Contact Middle Name

Street Address

Street Address

City State Zip Code

Home Phone Work Phone Cell Phone

Provide a secondary Emergency contact with different phone numbers than the primary Emergency Contact

Secondary Emergency Contact Relationship to Patient

Secondary Emergency Contact Last Name

Secondary Emergency Contact First Name

Secondary Emergency Contact Middle Name

Emergency Home Phone Emergency Work Phone

Emergency Cell Phone

Please be sure to bring the original insurance card(s) when returning this completed form. A copy of the front and back of the original insurance card will be made before the patient sees the provider. The patient or responsible parent or guardian is responsible to notify the practice of any changes to this information such as new insurance cards, etc.