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

Current Date

Required Patient Information

(The Patient is present with a Legal Guardian)

Last Name

First Name

Middle Name

Street Address

Street Address

City State Zip Code

Home Phone Work Phone Cell Phone

D.O.B Sex: SSN Marital Status

Emergency Contact Full Name

Relationship to Patient

Emergency Home Phone Emergency Work Phone

Emergency Cell Phone

Patient Employment Status Occupation

Name of Employer

Street Address

Street Address

City State Zip Code

Work Phone Work Extension

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

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Required Patient Information

(The Patient is present with a Legal Guardian)

Please supply the following additional information below about the Patient

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 faxed directly 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 ______

The patient is responsible to notify the medical practice of any changes of the information supplied in the completed form. The patient may be asked to tell staff the the exact information supplied in the form allowing staff to check the completed form for any changes. If it is determined that information has change since last seeing Earl V. Wilkinson, M.D. the patient will be required to complete a new patient registration form.

Please continue and complete all section of this form that apply and return the completed form to the medical practice

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

If the patient is a minor the parent or responsible guardian 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

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Current Date

(The Patient is present with a Legal Guardian)
Please supply the following information below about the Patient's Legal Guardian

Last Name

First Name

Middle Name

Street Address

Street Address

City State Zip Code

Home Phone Work Phone Cell Phone

D.O.B Sex: SSN Marital Status

Emergency Contact Full Name

Relationship to Patient

Emergency Home Phone Emergency Work Phone

Emergency Cell Phone

Guardian's Employment Status Occupation

Name of Employer

Street Address

Street Address

City State Zip Code

Work Phone Work Extension

Please fill information below about two family members not residing with the Patient's Legal Guardian

Relationship to first family member	Relationship to second family member
Last Name	Last Name
First Name	First Name
Middle Name	Middle Name
Street Address	Street Address
Street Address	Street Address
City	City
State Zip Code	State Zip Code
Home Phone	Home Phone
Work Phone Work Extension	Work Phone Work Extension
Cell Phone	Cell Phone

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REGISTRATION **(please print)**

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

Current Date ____________

(The Patient is present with a Legal Guardian)
Please supply the following information below about the
<u>Patient's Father</u>

Last Name ____________

First Name ____________

Middle Name ____________

Street Address ____________

Street Address ____________

City ____________ State ____________ Zip Code ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

D.O.B ____________ Sex: ____________ SSN ____________ Marital Status ____________

Emergency Contact Full Name ____________

Relationship to Patient ____________

Emergency Home Phone ____________ Emergency Work Phone ____________

Emergency Cell Phone ____________

Parent's Employment Status ____________ Occupation ____________

Name of Employer ____________

Street Address ____________

Street Address ____________

City ____________ State ____________ Zip Code ____________

Work Phone ____________ Work Extension ____________

Please fill information below about two family members not residing with the Patient's Father

Relationship to first family member ____________	Relationship to second family member ____________
Last Name ____________	Last Name ____________
First Name ____________	First Name ____________
Middle Name ____________	Middle Name ____________
Street Address ____________	Street Address ____________
Street Address ____________	Street Address ____________
City ____________	City ____________
State ____________ Zip Code ____________	State ____________ Zip Code ____________
Home Phone ____________	Home Phone ____________
Work Phone ____________ Work Extension ____________	Work Phone ____________ Work Extension ____________
Cell Phone ____________	Cell Phone ____________

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REGISTRATION (please print)

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

Current Date

(The Patient is present with a Legal Guardian) Please supply the following information below about the Patient's Mother

Last Name

First Name

Middle Name

Street Address

Street Address

City State Zip Code

Home Phone Work Phone Cell Phone

D.O.B Sex: SSN Marital Status

Emergency Contact Full Name

Relationship to Patient

Emergency Home Phone Emergency Work Phone

Emergency Cell Phone

Parent's Employment Status Occupation

Name of Employer

Street Address

Street Address

City State Zip Code

Work Phone Work Extension

Please fill information below about two family members not residing with the Patient's Mother

Relationship to first family member	Relationship to second family member
Last Name	Last Name
First Name	First Name
Middle Name	Middle Name
Street Address	Street Address
Street Address	Street Address
City	City
State Zip Code	State Zip Code
Home Phone	Home Phone
Work Phone Work Extension	Work Phone Work Extension
Cell Phone	Cell Phone

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

Current Date

First or Primary Insurance Information

Insurance Company Name

Indicate the address where medical claims must be submitted found on the back of the insurance card or found by calling the insurance company

Street Address

Street Address

City State Zip Code

Members' Phone Providers' Phone

This section must be filled out regarding information about the Guarantor of the primary insurance policy who is responsible for paying the monthly insurance premium. If the Guarantor is the same as the patient please state "same as patient"

Subscriber # /Member #/ Policy #

Group#

insurance Policy Holder's Last Name

insurance Policy Holder's First Name

insurance Policy Holder's Middle Name

insurance Policy Holder's Street Address, if no different than the Patient's than state "same as patient"

Street Address

Street Address

City State Zip Code

Home Phone Work Phone Cell Phone

D.O.B Sex: SSN Relationship to Insured

Guarantor Employment Status Occupation

Name of Employer

Street Address

Street Address

City State Zip Code

Work Phone Work Extension

Names of other dependents covered under this plan

Please be sure to bring the original primary insurance card 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.

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REGISTRATION (please print)

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

Current Date ______

Second or Secondary Insurance Information

Insurance Company Name ______

Indicate the address where medical claims must be submitted found on the back of the insurance card or found by calling the insurance company

Street Address ______

Street Address ______

City ______ State ______ Zip Code ______

Members' Phone ______ Providers' Phone ______

This section must be filled out regarding information about the Guarantor of the secondary insurance policy who is responsible for paying the monthly insurance premium. If the Guarantor is the same as the patient please state "same as patient"

Subscriber # /Member #/ Policy # ______

Group# ______

insurance Policy Holder's Last Name ______

insurance Policy Holder's First Name ______

insurance Policy Holder's Middle Name ______

insurance Policy Holder's Street Address, if no different than the Patient's than state "same as patient"

Street Address ______

Street Address ______

City ______ State ______ Zip Code ______

Home Phone ______ Work Phone ______ Cell Phone ______

D.O.B ______ Sex: ______ SSN ______ Relationship to Insured ______

Guarantor Employment Status ______ Occupation ______

Name of Employer ______

Street Address ______

Street Address ______

City ______ State ______ Zip Code ______

Work Phone ______ Work Extension ______

Names of other dependents covered under this plan ______

Please be sure to bring the original secondary insurance card 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.

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

Current Date

Third or Tertiary Insurance Information

Insurance Company Name ______

Indicate the address where medical claims must be submitted found on the back of the insurance card or found by calling the insurance company

Street Address ______

Street Address ______

City ______ State ______ Zip Code ______

Members' Phone ______ Providers' Phone ______

This section must be filled out regarding information about the Guarantor of the tertiary insurance policy who is responsible for paying the monthly insurance premium. If the Guarantor is the same as the patient please state "same as patient"

Subscriber # /Member #/ Policy # ______

Group# ______

insurance Policy Holder's Last Name ______

insurance Policy Holder's First Name ______

insurance Policy Holder's Middle Name ______

insurance Policy Holder's Street Address, if no different than the Patient's than state "same as patient"

Street Address ______

Street Address ______

City ______ State ______ Zip Code ______

Home Phone ______ Work Phone ______ Cell Phone ______

D.O.B ______ Sex: ______ SSN ______ Relationship to Insured ______

Guarantor Employment Status ______ Occupation ______

Name of Employer ______

Street Address ______

Street Address ______

City ______ State ______ Zip Code ______

Work Phone ______ Work Extension ______

Names of other dependents covered under this plan ______

Please be sure to bring the original tertiary insurance card 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.