



EAR / OTITIS QUESTIONNAIRE (Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Give diagnosis of ear disorder: _____

2. Date diagnosed or date of first symptoms: _____

3. How many episodes in the past 2 years? _____
Frequency of episodes? _____

4. Give details including dates of past and current treatment: _____

5. Any prescription medications taken for this condition? ___ Yes ___ No

Name of Medication:	Dosage	Frequency (ie, daily, as needed)
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Give name and address of treating physician: _____

7. Date last seen for this condition? _____

8. Ever had or been advised to have surgery? ___ Yes ___ No

If yes, give details: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge.
I understand that the insurer will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

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