



# 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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