Please Print Clearly, in blue or black INK

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Address (Street) _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

☐ Male ☐ Female Birth Date _____ Age _____

Social Security # _____ Patient's Occupation _____

Email Address _____

Employer _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Spouse's Name _____ Parent's Name(s) (if patient is under 18) _____

Referred by: _____

Primary Physician _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

How did you hear about us? (Please check one):

☐ Referred by Physician ☐ Referred by Friend/Family (name) _____

☐ Newspaper Ad (name) ☐ Phonebook ☐ Online ☐ TV ☐ Mail ☐ Other

INSURANCE INFORMATION (Please Submit Copies)

This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claims.

Primary Insurance _____

Address _____

Phone # _____ Insurance ID# _____ Group ID# _____

Primary Cardholder _____ Birthday _____ Relationship _____

Primary Cardholder's Employer _____ Social Security # _____

Address of Cardholder if Different from Patient _____

Secondary Insurance _____

Address _____

Phone # _____ Insurance ID# _____ Group ID# _____

Primary Cardholder _____ Birthday _____ Relationship _____

Primary Cardholder's Employer _____ Social Security # _____

Address of Cardholder if Different from Patient _____

SIGNATURE AUTHORIZATION

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. Center for Hearing will be happy to assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is also my responsibility to contact my insurance carrier to determine if Center for Hearing is in my specific network.

I authorize Center for Hearing to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.

I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Preferred method of contact for follow up / appointment confirmation: ☐ Phone ☐ Email ☐ Text Message ☐ Postcard

Signature _____ Date _____