Patient Information

First Name______________________________ **Preferred Name**________________________________

Middle Name______________________________**Last Name**___________________________________

DOB_____________ **Gender** (check one) ☐ Male ☐ Female ☐ Unspecified

Address___________________________________ **City**____________________ **Zip Code**_____________

Home Phone_______________________________ **Mobile Phone**_____________________________

Email Address____

Contact Method (check one) ☐ Primary Phone ☐ Mobile Phone (text or call) ☐ Email

Employer______________________________________ **Employer's Phone**____________________

Legal Guardian (if patient is a minor) _____________________________________

Responsible Party_______________________________**Responsible Parties SSN** ___________________________

Referring Physician_____________________________ **Primary Care Physician**___________________________

Marital Status (check one) ☐ Single ☐ Married ☐ Other

Name of Spouse____

Emergency Contact______________________________________ **Phone**_______________________

Insurance

Policy Holder if different than Patient_________________________________ **DOB**_____________

Relationship to Patient______________________ **Phone**__________________________

Address if different than Patient____

Please remember that some insurance pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.
I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or audiology benefits to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to. This assignment will remain in effect until revoked by me in writing. A photocopy of this assessment shall be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance.
I hereby authorize assignee to release all information necessary to secure the payment.

Please Sign____Date ________