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PATIENT INFORMATION

Date: ____________________

Patient Name____ DOB____/_____/____Age____
First MI Last

Home Phone #______________________________ Cell Phone #____________________________

Work Phone #______________________________ Email Address ____________________________

Mailing Address ____

Occupation ____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse/Guardian Name____

Emergency Contact__________________________ Phone # _______________________________

Relation to Patient ____

Referring Physician__________________________ Phone # _______________________________

Address ____

Would you like us to send results to this physician? ☐ Yes ☐ No

If patient is under the age of 18, please provide:

Father's Name______________________________ Mother's Name _________________________

Work Phone________________________________ Work Phone ____________________________

POLICY HOLDER INFORMATION

Primary Insurance___________________________ Policy #________________ Group #__________

Policy Holder ______________________________ Relationship ____________ DOB_____________

Policy Holder Employer ____________________________________ Phone # __________________

Secondary Insurance_________________________ Policy #________________ Group #__________

Policy Holder ______________________________ Relationship ____________ DOB_____________

Policy Holder Employer ____________________________________ Phone # __________________

How did you hear about us? ____

MEDICARE/INSURANCE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of Medicare and/or insurance benefits to be made directly to Assured Audiology & Hearing Solutions for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration any information needed to determine benefits or benefits payable for related services.

I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of services rendered.

I,____________________________ hereby acknowledge that I have received or viewed a copy of this practice's Notice of Privacy Practices.

_________________________________ ________________
Patient/Guardian/Parent Date

*Patients are responsible for understanding their insurance benefits.