Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone #_____Cell Phone # _____

Email _____

Mailing Address (Street) _____

City _____State _____Zip Code _____

Employed By _____

Primary Care Physician _____Phone #_____

Whom may we contact in case of an emergency? _____ Phone # _____

Whom may we thank for referring you to our office? _____

Primary Insurance Company _____Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth _____

Secondary Insurance Company _____Insurance ID# _____

I authorize Audiology and Hearing Aid Center, LLC to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this is information is correct to the best of my knowledge. I will notify Audiology and Hearing Aid Center, LLC of any changes in my health status or in the above information.

Signature _____Date _____

Parent Signature if Minor _____Date _____