(((The Hearing Center)))

New Patient Information

Name: _____DATE: _____

Address: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status (circle One) S M D W

RESPONSIBLE FOR BILLING (circle one) Self/parent/other

Name: _____ DOB: _____

Address: _____

Work Information:

Employer: _____

Address: _____

Insurance Coverage (insurance card must be present at the time of visit)

Primary Insurance:

Insurance Company: _____ Insurance ID: _____

Group #_____

Cardholder Name: _____ DOB: _____

Secondary Insurance:

Insurance Company: _____ Insurance ID: _____

Group # _____

Cardholder Name: _____ DOB: _____

Name of Physician: _____ Report Requested: (Y N)

All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical information necessary to my insurance company for the processing f my claims.

DATE: _____ SIGNATURE: _____