Please fill out form and bring along to your appointment.

PATIENT INFORMATION:

NAME: _____ADDRESS:_____

CITY_____ STATE_____ZIP_____PHONE:_____

CELL #_____ BIRTH DATE: _____SEX: _____ F_____ M

SPOUSE'S / PARENTS NAME: _____

EMPLOYMENT INFORMATION:

RETIRED_____ FULL-TIME_____ PART-TIME_____

EMPLOYER: _____ ADDRESS: _____

PHONE_____ **May we call you at work:** _____ YES _____ NO

FAMILY DOCTOR INFORMATION:

PRACTICE NAME: _____

FAMILY DOCTOR: _____

ADDRESS: _____ PHONE #_____

INSURANCE INFORMATION

PLEASE PRESENT CARD TO BE COPIED

Who can we thank for referring you here to this office (i.e. friend, physician, advertisement, ect.)

_____

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the release of any medical information necessary to process claims and permit a copy of this authorization to be used in place of the original. I authorize the Hearing & Ear Care Center to apply for benefits in my behalf for covered services rendered by them and that payment be made directly to the Hearing & Ear Care Center LLC. **I assume responsibility for all fees not covered by my insurance for goods and services rendered by The Hearing & Ear Care Center LLC throughout my course of treatment.**

SIGNATURE: _____ DATE: _____