PATIENT INFORMATION

Last Name: ________________________________ First Name: ________________________________ M.I.: ________

Address: ____ City, State, Zip: ________________________________

Home Phone: ________________________________ Cell Phone: ________________________________

Email: ____ Patient Social Security #: ________________________

Gender: **M F** Age: ________________ Date of Birth: ______________________

Married: **Yes No** Spouse/ Partner/ Significant Other Name: ______________________

Employer: __________________________ Occupation: __________________ Work Phone: __________________

Primary Care Physician Name: ____________________________ Primary Care Phone #: ______________________

Referred By: ____

If not noted above, how did you hear about us? ____

Have you made any changes to your Health Insurance / Medicare options in the last open enrollment period? **Yes No**

BILLING INFORMATION

Person Responsible for account: ____

Relationship to the patient: Self Spouse Parent/Guardian Partner

Primary Insurance Plan: ________________________________ **Subscriber Name:** __________________________

Subscriber SS#: ____________________________ **Subscriber Date Of Birth:** ______________________________

Insurance ID#: ________________________________ Group #: ____________________________________

Secondary Insurance Plan: ____________________ **Subscriber Name:** ____________________________________

Subscriber SS#: ____________________________ **Subscriber Date Of Birth:** ______________________________

Insurance ID#: ________________________________ Group #: ____________________________________

ACKNOWLEDGEMENT & RELEASE

The information provided above is true and accurate to the best of my knowledge. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered I will notify Hearing & Balance Lab of any changes in my status or in the above information.

____ ______________________

Signature of Patient / Guardian / Responsible Party Date

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