



Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

First MI Last Social Security # _____ / _____ / _____

Address: _____
Street Apt # City State Zip

Male/Female Married/Single/Divorced Cell Phone: _____

Home Telephone: _____ Employer Name: _____

E-MAIL ADDRESS: _____ Employer Telephone: _____

Spouse's Name: _____ Daytime Telephone: _____

Spouse's DOB: _____ / _____ / _____ Spouse's Employer: _____

Spouse's Social Security # _____ / _____ / _____ (only needed if spouse is the insurance policyholder)

PRIMARY INSURANCE: _____ PHONE: _____ we will make a photocopy

SECONDARY INSURANCE: _____ PHONE: _____ we will make a photocopy

In case of emergency, please contact: Name: _____ Relationship: _____

Telephone Number: _____

Who is your primary care physician? _____ Phone: _____

(If you would like a copy of your test results forwarded to your physician, please sign the release below)

Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

- | | | |
|------------------------|---------------------------------|------------------------|
| _____ Physician | _____ Vocational Rehabilitation | _____ Health Plan/HMO |
| _____ Audiologist | _____ Yellow Pages | _____ Attended Seminar |
| _____ Family Member | _____ Newspaper Ad/Article | _____ Internet |
| _____ Friend/Co-worker | _____ Hospital Referral Service | _____ Other: _____ |

Please provide the name of the person that referred you to our office: _____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to The Hearing Doctors, Inc. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____/_____/_____
Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize The Hearing Doctors, Inc. to release any and all medical information in the course of my treatment to the primary care physician listed above. I would also like to have this information forwarded to: _____

_____/_____/_____
Patient/Parent/Guardian Signature Date