NEW PATIENT INFORMATION

Must fill all information completely

Patient Name:_____ **Birth Date:**_____

____Male ____Female ____Child Age:_____

Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____**Work**_____**Cell**_____

Social Security#:__Not required_____**E-mail:**_____

Employer/Retired From:_____

Referred by:_____

(other than spouse)
Emergency Contact
Name:_____**Ph:**_____**Relationship:**_____

Physician Name _____ **Referring Physician**_____ _____

Primary Insurance Co. Secondary Insurances Co.

Name of Insurance_____ _____

Subscriber's name_____ _____

Employer: _____ _____

Subscriber #: _____ _____

Group #:_____ _____

INSURANCE INFORMATION (PLEASE PRESENT ALL INSURANCE CARD'S & PICTURE ID, FOR PHOTOCOPY)

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company.

I authorize the release of any medical information necessary to process my medial service claims, I permit a copy of this authorization to be used in place of the original. I hereby authorized Audiology & Hearing Services billing company to file for benefits on my behalf for medical service rendered. Insurance payments shall be made directly to Audiology & Hearing Services. If I have Medicare insurance, I authorize Audiology & Hearing Services to release to the Social Security and care financing administration or its intermediaries or carriers any information needed for this or related Medicare claim. I certify that I am financially responsible for all services not paid by insurances. This authorization is valid indefinitely until revoked by myself or by Audiology & Hearing Services by written request.

Signature _____ **Date** _____

Witness AHS_____ **Date** _____