Patient Personal Information

Patient Name: _____

Date of Birth: _____/_____/_____ **Sex: F M**

Spouse's Name: _____

Address: _____ **City:** _____
State: ____ **Zip Code**: _____

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

E-mail: _____**Would you like to receive our quarterly newsletter? Y N (We DO NOT give or sell our database info to anyone).**

Employer: _____ **Occupation:** _____

Are you: **full/time ____ part/time ____ not employed ____ self employed ____ retired ____**

How did you hear about us/ who can we thank for the referral?

_____
___

Primary Physician: _____ **Phone #**_____

Insurance Information

Insurance Co: _____**Subscriber Name**:_____

ID#_____-
_____DOB_____

Employer_____**Relationship to Insured**: **Self ___ Spouse __ Child __ Other___**

Secondary Insurance: Yes/No, if yes, carrier: _____

Subscriber Name: _____ DOB: _____ I.D. #
_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company above and assign directly to Conerstone Hearing Centers Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand

that I am financially responsible for all charges whether or not paid by the insurance company. To release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____Date: _____