DENTON HEARING HEALTH CARE

Primary Care Doctor________________________

Referral Source________________________

E-Mail Address:________________________

Date:________________________________

Patient Name:____

Date of Birth:________________________ Age:______________ Male:________ Female:__________

Social Security #:___________________________ Married:______________ Single:______________

Address:___________________________ City:______________ State:________ Zip:__________

Home Pho.#: ________________ Work Pho.# ____________________ Cell Pho.#________________

Please describe the type of problem you are experiencing:

____

____

____

Do you have a hearing aid at this time?:_______ Brand:_________________________________

DO YOU HAVE A PACEMAKER? Yes________ No________

Person responsible for account if different than above:

____

LAST NAME FIRST NAME MIDDLE INITIAL

Date of Birth:__________________________ Social Security #:__________________________

Employed by:__________________________ Business Phone:__________________________

Insurance Co.:____

Group #:__________________________ Subscriber #:__________________________

Please read the following:

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any professional services rendered.

By signing below, I also authorize release of my medical records for insurance purposes only. No other information will be released without my written consent.

Signature:____ Date: ____________________