Nanci Campbell AuD
Doctor of Audiology

Date: _____

Patient Name _____ ☐ Male ☐ Female
Last First MI

Mailing Address _____
Street City State Zip Code

Birth Date _____ Age ____ Social Security # _____ ☐ Married ☐ Single

Cell Phone _____ Home Phone _____ Student ☐ Fulltime ☐ Part ☐ None

Emergency Contact Name _____ Phone Number _____

Employed ☐ Yes ☐ No Retired Where _____

Work Phone _____ ☐ Fulltime ☐ Part

Primary Physician _____ Referring Physician _____

Email address _____ May we send you emails? ☐ YES ☐ NO

Please tell us how you heard about our office _____

Person Responsible for Account

Name _____ Social Security # _____
Last First MI

Mailing Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Relationship to Patient _____

Primary Insurance

Insurance Company Name _____

Subscriber Name _____Date of Birth _____ Relationship _____

Group # _____ ID # _____ Social Security # _____

Secondary Insurance

Insurance Company Name _____

Subscriber Name _____Date of Birth _____ Relationship _____

Group # _____ ID # _____ Social Security # _____

Assignment and Release

I hereby authorize Nanci Campbell, Au.D. to release any information required by appropriate agencies or insurance companies for purposes of filingclaims. I also authorize my insurance benefits to be paid directly to Dr. Campbell. I am financially responsible for any diagnostic services or assistive devices, including hearing aids, at the time of purchase and any appropriate co-payments and deductibles. We will bill your insurance for you, as a courtesy, but our relationship is with you, not your insurance company.

Patient or Guardian Signature _____ Date _____