Lisa C. Predmore, Au.D., P.C.

1165 Northern Boulevard, Suite 302
Manhasset, New York 11030
(516) 627-7600
(516) 627-6378 fax

140 Jackson Avenue
Syosset, New York 11791
(516) 496-7302
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PATIENT INFORMATION

NAME ______________________________

ADDRESS ___________________________

____

TELEPHONE (home) ____________________

(work) ____________________

LOCATION: M SY _______NH

Co pay____________ Referral Needed________

DOB: _________________________________

REFERRAL: ____________________________

DOCTOR: ______________________________

ADDRESS: _____________________________

____

PRIMARY INSURANCE: _________________________

NAME OF INSURED: ___________________

EMPLOYER: __________________________

RELATIONSHIP: ______________________

POLICY #: ____________________________

GROUP #: ____________________________

CATEGORY: __________________________

SECONDARY INSURANCE: ___________________________

NAMED OF INSURED: ____________________

EMPLOYER: _____________________________

RELATIONSHIP: _________________________

POLICY #: ______________________________

GROUP #: _______________________________

CATEGORY: ______________________________

I request that payment of authorized Medicare Benefits and/or any other insurance carrier benefits be made either to me or on my behalf to Lisa C. Predmore, Au.D., P.C. for services furnished to me by the Audiologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patients Signature: ____ Date: ________________

Audiologist's Signature: _____________________________________ Date: ________________