Name:____ Date of Birth:_______/______/______ Age:________
First MI Last
Address:____
Street Apt # City State Zip

Home Telephone:______________________________ Employer Name:______________________________
E-MAIL ADDRESS:______________________________ Employer Telephone:______________________________

Spouse's Name:______________________________ Daytime Telephone:______________________________
Spouse's Employer:______________________________ Date of Birth:_______/______/______

In case of emergency, please contact: Name:______________________________Relationship:______________
Telephone Number:____

PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS A MINOR (under 18 years of age)

Father's Name______________________________ Mother's Name:______________________________
Date of Birth: _______/______/______ Date of Birth: _______/______/______
Home Phone (if different)____________________ Home Phone (if different)____________________
Work Phone______________________________ Work Phone______________________________
Employer:______________________________ Employer:______________________________

Who is your primary care physician? ______________________________________Phone:________________________

(If you would like a copy of your test results forwarded to your physician, please sign the release below)

Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

_______Physician _______Vocational Rehabilitation _______Health Plan/HMO
_______Audiologist _______Yellow Pages _______Attended Seminar
_______Family Member _______Newspaper Ad/Article _______Internet
_______Friend/Co-worker _______Hospital Referral Service _______Other:______________

Please provider the name of the person that referred you to our office:______________________________________

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to Earmark Audiology, LLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

____ _______/______/______
Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I, ______________________________, hereby authorize Earmark Audiology, LLC to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above. I would also like to have this information forwarded to:____

____ _______/______/______
Patient/Parent/Guardian Signature Date