PLATTE VALLEY HEARING CENTER INC

Please Print Clearly Today's Date _____

Patient Name _____ Date of Birth ___/____/_____ Age _____

Address _____

City _____ State _____ Zip_____

Home Phone (_____) _____-_____ Work Phone (____) _____-_____ Sex M F

Cell Phone (_____) _____-_____ Email _____

Employer _____ Marital Status _____ Social Security #_____

Is your Condition Accident related? Y N Auto Work Other _____ Date of accident_____

Spouse/Parent/Guardian _____ Home Phone (_____) _____

Address _____ City _____ Work Phone (_____)_____

Family Physician_____ Address_____

How did you hearing about our office? _____

Emergency Contact NOT living with you _____ Phone (_____)_____

Would you like to receive our newsletter? _____ Be contacted by Email: Y N

INSURANCE INFORMATION

Primary Insurance _____ Subscriber # _____

Group # _____ Name of Insured _____

Relationship to Patient _____Birthdate of Insured _____/_____/_____

Social Security # of Insured _____ Address _____

Employer _____ Home Phone _____ Work _____

Secondary Insurance _____ Subscriber # _____

Group # _____ Name of Insured _____

Relationship to Patient _____Birthdate of Insured _____/_____/_____

Social Security # of Insured _____ Address _____

Employer _____ Home Phone _____ Work _____

Platte Valley Hearing Center, Inc Authorization and Release

I hereby assign to Platte Valley Hearing Center all benefits for medical expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance, including charges sent to collection agencies. I authorize Platte Valley Hearing Center to release my medical records and all medical information requested by my insurance company or Workman's Compensation carrier. I also authorize Platte Valley Hearing Center to release information to any hospital or physician I may be referred to by this office.

Patient/ Guardian Signature _____Date _____