THE HEARING CLINIC, INC.

PATIENT INFORMATION: *Please fill out completely to the best of your ability.*

Patient's Full Legal Name: _____

Nickname: _____ M F Date of Birth: _____

Social Security #: _____ Marital Status: Single Married Widowed Divorced Separated Minor

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

E-mail Address: _____

Patient's Employer: _____ Position: _____

Work Phone: ( ) _____ Best Way To Reach You: _____

Referred By: _____ Family Physician: _____

Where Did you Hear About us? _____ Was Hearing Loss Caused by Employment or Accident?: _____

RESPONSIBLE PARTY INFORMATION: (INSURANCE POLICY HOLDER)

Full Legal Name: _____ Relationship To Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Work Phone: ( ) _____

Date of Birth: _____ Social Security #: _____ Drivers License Number: _____

SPOUSE INFORMATION:

Spouse's Name: _____ Date of Birth: _____ SS#: _____

Employer: _____ Position: _____ Cell Phone: ( ) _____

Work Phone: ( ) _____

MINOR INFORMATION:

If Patient is a minor child lives with: Mother: _____ Father: _____ Other: _____
(Specify relationship)

Who brought the child in for this evaluation? _____

**** Please understand that it is our office policy for the above named person to be financially responsible for the child's account. ****

INSURANCE INFORMATION: **PLEASE BRING CARDS TO THE FRONT DESK FOR PHOTOCOPYING**

If card is unavailable for copying, patient will be considered self-pay until card is on file.

Do You Have Medical Insurance? YES NO We will file all primary insurance claims for you if furnished with the adequate information.

Medicare _____ Medicaid _____ Private Insurance _____ Workers' Comp _____ Other _____

PERSON TO CONTACT: **I HEREBY ACKNOWLEDGE THIS PERSON MAY BE CONTACTED AT ANY TIME ON MY BEHALF**

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO THE PROVIDER

Services are rendered on a Cash Basis unless previous arrangements have been made. All accounts over 30 days are subject to a Finance Charge of 1.33% per month, equal to 16% per year.

I hereby authorize payment of medical insurance benefits directly to **THE HEARING CLINIC, INC.** I understand that I am financially responsible for all charges whether or not paid by said insurance. I also authorize the release of any medical information to my insurance provider or other health care provider concerning my examination, diagnosis, and treatment. This assignment will remain in effect until revoked by me in writing.

SIGNATURE: _____ **DATE**: _____
Person responsible for bill (Patient/Spouse/Guardian/POA)