Chart #:_________
(office use only)

Name: _________________________________ Date of Birth: ________________

Address: _________________________________ Social Sec. #: _______________

City:____________________________ State: _____ ZIP: ________ Male❒
Female ❒

Phone Number(s):
home:______________ cell:________________ emergency:_________________
e-mail:______________________________________________________________

Marital status: Single ❒ Married ❒ Divorced❒ Widow(er) ❒

Relation to insured: Self ❒ Spouse ❒ Child ❒

Insured's name: _______________________ Insured's Date of Birth: __________
(if other than self) (if other than self)

Primary Care Physician: ________________Referring Physician:_______________

Primary Insurance: __________________ Supplement Insurance:_____________

**Medicare patients**: We accept Medicare for all audiological testing, but Medicare does not pay for hearing aids or any services related to hearing aids. You will be responsible for those charges and any charges not covered by Medicare such as deductibles and co-pays.

**HMO/PPO patients**: We have contracted with most insurance carriers to accept a co-pay, therefore, your payment today will be determined on an individual basis.

I agree to pay all charges for health care services not covered by or which exceed the amount to be paid by Medicare, my insurance company, or other third party payor to Audiology Associates of East Texas.

**AUTHORIZATION TO RELEASE INFORMATION**
I authorize this office to release any information acquired in the course of my examination to other physicians and/or treatment centers.

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

Patient's signature: _________________________________ Date: _______________