Raleigh
Hearing and Tinnitus Center

919-790-8889
Fax: 919-865-2875

www.raleighhearingandtinnituscenter.com 10010 Falls of Neuse Rd Ste12 - Raleigh, NC 27614

Patient Information

Date of Completion: _____

Salutation: _____ **First Name:** _____ **Last Name:** _____ **MI:** _____
(Mr., Mrs., Dr., etc.)
Date of Birth: _____ **Gender:** M or F **Email:** _____

Mailing Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Cell Carrier:** _____
(for text appt reminders)

Marital Status: Single Married Partner Divorced Widowed **Name (if applicable):** _____

Employment Status: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Practice: _____ Phone: _____

Practice Address: _____ City/State/Zip: _____

May we send your records to your physician?: Yes or No

How did you hear about us? _____

Primary Insurance: _____ Subscriber/Policy #: _____

Name of Insured: _____ Date of Birth: _____

Secondary Insurance: _____ Subscriber/Policy #: _____

Name of Insured: _____ Date of Birth: _____

I authorize Raleigh Hearing and Tinnitus Center to release information requested with regard to processing my claims. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify that the information on this sheet is correct to the best of my knowledge. I will notify Raleigh Hearing and Tinnitus Center of any changes in my health status or in the above information.

Signature: _____ **Date:** _____

Date: _____ **No Changes:** _____ **Changes:** _____
Date: _____ **No Changes:** _____ **Changes:** _____
Date: _____ **No Changes:** _____ **Changes:** _____