Hearing & Audiology Services

FULL NAME: _____ DOB: _____

STREET ADDRESS:_____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: _____CELL:_____WORK: _____

EMAIL ADDRESS:_____

CIRCLE ONE: **MALE / FEMALE

**MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED / LEGALLY SEPARATED

**EMPLOYMENT: FULL/PART TIME / SELF EMPLOYED / UNEMPLOYED / RETIRED / STUDENT

SPOUSE INFORMATION:

NAME: _____CONTACT NUMBER: _____

EMERGENCY CONTACT: NAME _____ NUMBER _____

PATIENT'S PRIMARY PHYSICIAN: _____

CLINIC/PRACTICE NAME/ADDRESS:

_____

*No need to fill out insurance information if you have provided us with your insurance card information.

INS.CO.:_____ADDRESS:_____

POLICY / GROUP#:_____/ _____

INS CO._____ADDRESS:_____

POLICY / GROUP#:_____/ _____

DATE/ PRACTICE NAME & ADDRESS LAST TESTED:

_____

_____

HOW DID YOU HEAR ABOUT HEARING & AUDIOLOGY SERVICES? _____

_____

Release of information and Assignments of Benefits Declaration

I hereby authorize the release of any medical information necessary to process my insurance claim and assign to H.A.S. all payments from my insurance carrier/s rendered. I understand and agree to the above condition.

I have received a copy of the Notice of Privacy Practices for the above-named practice.

Signature_____ Date _____