

PATIENT INFORMATION

Last Name: _____ First: _____ M.I.: _____
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____ Marital Status: _____ Spouse's Name: _____
Social Security #: _____ Gender: _____ Age: _____ Date of Birth: _____
Employer: _____ Occupation: _____ Work Phone: _____
Primary Care Physician: _____ Physician's Phone: _____
Referred by: _____
If not noted above, how did you hear about us? _____

BILLING INFORMATION

Person Responsible for Account: _____
Relationship to Patient: Self Spouse Parent/Guardian Other: _____
Employer: _____ Work Phone: _____
Social Security # _____ Date of Birth: _____
Primary Insurance Plan: _____ Subscriber: _____
Group #: _____ I.D.#: _____ Date of Birth: _____
Secondary Insurance Plan: _____ Subscriber: _____
Group #: _____ I.D.#: _____ Date of Birth: _____

ASSIGNMENT AND RELEASE

Assignment and release: I hereby authorize The Hearing & Balance Lab, PC to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to The Hearing & Balance Lab, PC and I am financially responsible for any unpaid balance.

Signature of Patient or Guardian _____ Date: _____