

Patient Information Form

Legal First Name: _____ M.I.: ____ Last Name: _____ Birth Date _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Social Security Number _____

Cell Phone: (_____) _____ - _____ Gender: M/F Marital Status: Married/ Single/ Divorced

Employer: _____ Work Phone: _____

Emergency Contact: _____ (_____) - _____ - _____

Primary Care Physician

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Referring Physician

Responsible Party and Billing Information

First Name: _____ M.I.: ____ Last name: _____

Address: _____

Phone: (_____) _____ - _____ Social Security Number: _____

Insurance Information: PLEASE COMPLETE

Primary Insurance Company: _____

Address: _____

Street, City, State, Zip

ID #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Company: _____

Address: _____

ID #: _____ Group #: _____

Subscriber Name: _____ Birth Date : _____ Relationship to Patient _____

I authorize Center for Better Hearing, LLC 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 have read all the information on this sheet, and certify that this is information is correct to the best of my knowledge. I will notify Center for Better Hearing, LLC of any changes in my health status or in the above information.

Date: _____

Patient/Responsible Party Signature