Please fill out form and bring along to your appointment.

Hearing and Ear Care Center, LLC
806 W Main Street
Mount Joy, PA 17552
717-653-6300

Hearing and Ear Care Center, LLC
200 Schneider Dr. Suite 1
Lebanon, PA 17046
717-274-3851

PATIENT INFORMATION:

NAME: _____ADDRESS:_____

CITY_____ STATE_____ZIP_____PHONE:_____

CELL #_____ BIRTH DATE: _____ SEX: _____ F_____ M

SPOUSE'S / PARENTS (If Patient is a minor) NAME: _____

EMAIL ADDRESS:_____

EMPLOYMENT INFORMATION:

RETIRED_____ FULL-TIME_____ PART-TIME_____

EMPLOYER: _____ ADDRESS: _____

PHONE_____ **MAY WE CALL YOU AT WORK:** _____ YES _____ NO

FAMILY DOCTOR INFORMATION:

PRACTICE NAME & LOCATION: _____

FAMILY DOCTOR: _____ PHONE# _____

INSURANCE INFORMATION

****PLEASE PRESENT CARD TO BE COPIED****

Who can we thank for referring you here to this office (i.e. friend, physician, advertisement, etc.)

_____

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the release of any medical information necessary to process claims and permit a copy of this authorization to be used in place of the original. I authorize the Hearing & Ear Care Center to apply for benefits in my behalf for covered services rendered by them and that payment be made directly to the Hearing & Ear Care Center LLC. **I assume responsibility for all fees not covered by my insurance for goods and services rendered by The Hearing & Ear Care Center LLC throughout my course of treatment**.

SIGNATURE: _____ **DATE:**_____