Factoria Hearing Center
12600 Se 38th St, Suite 104
Bellevue, WA 98006
Phone: 425-457-7999

Patient Intake Information

Name____ Date ______________
First Initial Last

Address____

City__________________________________ State __________ Zip Code______________________

Home Phone ( )______________ Work Phone ( )________________Email____________________

Soc Sec #______________Date of Birth ___________Sex: M F Marital Status: Married Single Other

Employment StatusFull-time Part-time None Student Status Full-time Part-time None

Primary Physician____

Whom may we thank for referring you?____

In case of emergency who should be notified?____

Primary Insurance Information ***(if patient is also the insured, enter 'SAME' for name & address)***

Insured's Name____
First Initial Last

Address ____

City ___________________________________State _______ Zip Code________________

Home Phone ( ) ___________________ Work Phone ( ) _____________________________

Patient Relation to Insured: Self Spouse Child Insured Date of Birth____________ Insured Sex: M F

Insured Employment Status: Full-time Part-time Retired Insured Employer__________________________

Insurance Co. Name_________________Subscriber ID Number ______________Group Number____________

Other Insurance Information ***(if patient is also the insured, enter 'SAME' for name & address)***

Subscriber ID Number________________________________Group Number___________________________

RELEASE OF INFORMATION AND PAYMENT GUARNATEE

The undersigned herby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature authorizes Factoria Hearing Center to submit claims for benefits rendered. I understand that I am financially responsible for all charges incurred and understand that any insurance benefits paid will be credited to my account in accordance with the above assignment. I authorize release of information to my insurance company, to myphysician, and to the following other parties, with the reason noted.

Subscriber Signature ______________________________Date________________________

Signature of Patient Guardian ________________________Date________________________