NAME: _____

ADDRESS: _____

CITY: _____ **STATE** _____ **ZIP CODE:** _____

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____ **EMAIL:** _____

DOB: _____ **MARITAL STATUS** _____ **SPOUSE NAME:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

RELATIONSHIP TO PATIENT: _____

PRIMARY INSURANCE: _____

POLICY HOLDER NAME (IF OTHER THAN PATIENT): _____

DOB of POLICY HOLDER: _____ **RELATIONSHIP TO PATIENT:** _____

POLICY ID : _____ **GROUP NUMBER:**_____

SECONDARY INSURANCE: _____

POLICY HOLDER NAME (IF OTHER THAN PATIENT): _____

DOB of POLICY HOLDER: _____ **RELATIONSHIP TO PATIENT:** _____

POLICY ID : _____ **GROUP NUMBER:**_____

PHYSICIAN: _____ **PHONE :** _____

LIST OF CURRENT MEDICATIONS: _____

_____

_____

_____

I understand that I will be responsible for any balance or charges that are not covered by my insurance. If I have a co-payment with my insurance, it is payable at the time services are rendered. If I do not have insurance to cover audiology services, I am solely responsible for the charges and it is payable when services are rendered. All returned checks will be assessed a $30.00 fee. The check amount and the fee are due within 10 days from notification. I have read, understood and agree to the financial policies above.

Patient/Responsible Party _____ **Date:** _____