Advanced Hearing Center, LLC

Patient Information

Patient's Name _____ Date _____

Address _____

Phone _____ Cell Phone _____

Date of Birth _____ Primary Care Physician _____

Insurance Information

Primary Insurance Company Name _____

Address _____

ID Number _____Group Number _____

Secondary Insurance Company Name _____

Address _____

ID Number _____Group Number _____

Policyholder Information

Primary Policyholder's Name _____

Address _____

Phone _____ Date of Birth _____

Secondary Policyholder's Name _____

Address _____

Phone _____ Date of Birth _____

Responsible Party Information (Please complete if the person responsible for paying the bill is not the patient or policyholder).

Responsible Party Name _____ Phone _____

Address _____

Relationship to Patient _____

Patient's Signature _____ Date _____