PATIENT DEMOGRAPHICS

First name: _____ Last name: _____ Middle initial_____

DOB: _____ Sex: _____

Home phone number: _____ Cell phone number: _____ Consent to text: (YES/ NO)

Email address: _____ Consent to email: (YES/ NO)

Address: _____ City: _____ State/Zip: _____

Marital status: (Single/ Married/ Divorced/ Widowed/ Other) _____

Employment status: (Full time/ Part time/ Retired/ Unemployed) - Profession: _____

Referral source (how did you find out about us?): _____

INSURANCE

Carrier(s): _____ Subscriber: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

Full Name: _____ Phone number: _____

Relationship: _____

PHYSICIAN INFORMATION

Primary care provider: _____ Phone number: _____

Address: _____ City: _____ State/Zip:_____

CONSENT TO TREAT

1. I authorize Anne Arundel Audiology to provide me medical treatment as outlined within the scope of practice of the rendering provider.
2. I allow Anne Arundel Audiology to file for insurance benefits to pay for the care I receive. In doing so, I understand the following: Anne Arundel Audiology may have to send my medical record information to my insurance company. I authorize payment of medical benefits to be made directly to Anne Arundel Audiology for services rendered. If there is any out-of-pocket amount that my insurance doesn't cover, I understand that I will be liable in paying the cost difference. This authorization shall remain in effect until I state otherwise, in writing.
3. I understand that I have the right to refuse any procedure or treatment.

_____ _____

Printed name Signature

_____

Date