

Please Print Clearly, in
blue or black INK

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____
 Address (Street) _____
 City _____ ST: _____ Zip: _____
 Home Phone: _____ Work Phone: : _____ Cell: : _____
 Birth Date _____ Age: _____ Male _____ Female _____
 Social Security # _____ Patient's Occupation: _____
 Email Address: _____
 Employer _____
 Marital Status: Married _____ Divorced _____ Single _____ Separated _____ Widowed _____
 Spouse's Name _____ Parent's Name(s) (if pt. is under 18) _____
 Referred by: _____
 Primary Physician: _____ Phone # _____
 Emergency Contact: _____ Phone # _____
 How did you hear about us? (Please check one):
 _____ Referred by Physician _____ Referred by Friend/Family(name) _____
 _____ Newspaper Ad (name) _____ Phonebook _____ Online _____ Other _____

Insurance Information (Please submit Copies)

This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claims.

Primary Insurance: _____
 Address: _____
 Phone#: _____ Group ID#: _____ Insurance ID#: _____
 Primary Cardholder _____ Birthdate _____ Relationship _____
 Primary Cardholder's employer: _____ Social Security #: _____
 Address of Cardholder if Different from Patient: _____
 Secondary Insurance: _____
 Address: _____
 Phone #: _____ Group#: _____ ID# _____
 Primary Cardholder: _____ Birthdate: _____ Relationship: _____
 Primary Cardholder's employer: _____ Social Security #: _____
 Address of Cardholder if Different from Patient: _____

SIGNATURE AUTHORIZATION

Audiology Hearing Care Services, Inc. is a privately owned company and all scheduling will be conducted through the corporation I understand that I am ultimately responsible for the balance on my account for any professional services rendered. AHCS will be happy to assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is also my responsibility to contact my insurance carrier to determine if AHCS is in my specific network.

I authorize AHCS. to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.

I understand that it is my responsibility to notify AHCS if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" fee for which I will assume responsibility. I also permit a copy of this authorization to be used in place of the original. I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Signature: _____ Date: _____