



Fellow, American Academy of Audiology
Board Certified in Audiology

Patient Information

Date _____ Home Phone _____

Patient Name _____ Social Security # _____ - ____ - ____
Last Name First Name Initial

Address _____ City _____ State _____ Zip _____

Please circle one: Single Married Other Sex: Male Female Age _____ Date of Birth ____/____/____

Employer _____ and/or School Name _____

Referring Physician _____ Primary Care Physician _____

Email Address _____ May we email you? yes no

Primary Insurance Information

Person responsible for account _____
Last Name First Name Initial

Relation to Patient _____ Date of Birth ____/____/____/ Drivers License # _____

Address (if different from patient) _____ Daytime Phone _____

Person Responsible Employed by _____ Social Security # _____ - ____ - ____

Insurance Company _____ Address _____ State _____ Zip _____

Policy or Subscriber Number _____ Group Number _____

Additional Insurance

Subscriber Name _____ Date of Birth ____/____/____/ Driver's License # _____

Subscriber Employed by _____ Daytime Phone # _____

Insurance Company _____ Social Security # _____ - ____ - ____

Policy or Subscriber Number _____ Group Number _____

PLEASE COMPLETE NEXT PAGE.



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Assignment and Release

I, the undersigned, have insurance coverage with _____, and assign directly to Phillip Allred all medical payments and benefits otherwise payable to me. If I am covered by MEDICARE, I understand that I will be responsible for all non-covered procedures by MEDICARE (office visit, ear cleaning, and hearing aids). I understand that I am responsible for all charges whether or not they paid by my insurance. If my bill is sent to collections, I am responsible for collection fees. I hereby authorize the release of all information necessary to secure payment of benefits as well as all reports to my physician(s). I authorize the use of this signature on all insurance submissions.

Signature

Relationship to patient

Date