Comprehensive Case History Form

Last Name: _________________________________ First Name: __________________________ MI: __________

Address: ____

City, State and Zip: ____________________________________ Date of Birth: ____

Home Phone: ____ Cell Phone: ____

Work Phone: ____ Email Address: ____

Emergency Contact/Relationship: ____ Phone: _______________________________

Other than yourself, with who else can we share/discuss results? ____

Sex: Male [ ] Female [ ]

Employment status: Full Time [ ] Part Time [ ] Unemployed [ ] Student [ ] Retired [ ]

Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ] Domestic Partner [ ]

Referring Physician: ___________________________________ **Primary Physician**: ______________________________________

I would like my written report to be sent to the following physicians: ____

INSURANCE INFORMATION

Primary Insurance:

Plan Name: ____________________________ Policy/ID#_____________________________ Group# _____________________

Subscriber's Name: _____________________________ Patient Relationship to Subscriber: _______________________________

Subscriber's DOB: ______________________________ Subscriber's Employer: ____

Secondary Insurance:

Plan Name: ____________________________ Policy/ID#_____________________________ Group# _____________________

Subscriber's Name: _____________________________ Patient Relationship to Subscriber: _______________________________

Subscriber's DOB: ______________________________ Subscriber's Employer: ____

***If you have a third insurance carrier please let us know**

Person responsible for payment for services rendered by Freedom Hearing Center

Guarantor Name: ____

Address: ____ Phone: ____________________________________

City, State, and Zip: ____

If the patient is a minor, who is/are the legal guardian(s)? ____

I certify that the information I have reported on this form is correct to the best of my knowledge. I understand that if any changes are made to the information above that I notify Freedom Hearing Center. I authorize Freedom Hearing Center to disclose any necessary health information needed for treatment and or payment of services received. I also authorize release of health care information to other health care providers for continuing care and treatment. Lastly, I authorize Freedom Hearing Center to collect any payment made by insurance carrier for services rendered and billed by Freedom Hearing Center. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. **I understand that nothing herein relieves me of the responsibility and obligation to pay for medical services provided and items purchased when a statement is rendered. Delinquent accounts incur collection, court, and attorney expenses.**

____ ____

Signature of Patient or Guardian Date