

PATIENT INFORMATION

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: _____

Sex: Male [] Female []

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

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

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

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***

Many insurance carriers require referral from your Primary Care Physician before you receive care from a specialist; **IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL OR PRIOR AUTHORIZATION IF YOUR MEDICAL COVERAGE REQUIRES IT.**

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