FREEDOM
Hearing Center LLC

Comprehensive Case History Form

Last Name: _____ First Name: _____ MI: _____

Address: _____

City, State and Zip: _____

Home Phone: _____ Date of Birth: _____

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**: _____

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.

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. This consent is valid for one year and I understand that I will need to provide current information on an annual basis. I authorize Freedom Hearing 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 to collect any payment made by insurance carrier for services rendered and billed by Freedom Hearing. 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**