

PATIENT INFORMATION

PATIENT NAME				AGE	BIRTH DATE
FIRST	MIDDLE	LAST			
ADDRESS				SEX	
CITY		STATE	ZIP	MARITAL STATUS	
				S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>	
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL		
EMPLOYER			OCCUPATION		
SPOUSE NAME (IF APPLICABLE)		BIRTH DATE	EMPLOYER		
REFERRING DOCTOR			PRIMARY PHYSICIAN		

ACCOUNT INFORMATION

RESPONSIBLE PARTY				BIRTH DATE
FIRST	MIDDLE	LAST		
MAILING ADDRESS				SOCIAL SECURITY
CITY		STATE	ZIP	RELATIONSHIP TO PATIENT
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL	
EMPLOYER		EMPLOYER ADDRESS		

MEDICAL INSURANCE INFORMATION

PRIMARY INS.	INS. COMPANY NAME	ADDRESS	CITY	STATE
SUBSCRIBER'S NAME		BIRTHDATE	EMPLOYER (IF GROUP COVERAGE)	
ID NO.	GROUP NO.	CLAIM NO. (IF MVA OR WORKERS COMP)		
OTHER INS.	INSURANCE COMPANY	I.D. NO.	GROUP NO.	
SUBSCRIBER'S NAME		BIRTHDATE	EMPLOYER	

EMERGENCY CONTACT

NAME			RELATIONSHIP
ADDRESS			PHONE
CITY	STATE	ZIP	

I authorize release of medical information to my insurance company or third party payer for billing. I also authorize payment directly to Mid-Valley Hearing Center. A quoted insurance benefit is not a guarantee of payment. I understand that I am financially responsible to Mid-Valley Hearing Center for all charges not covered by insurance. In the event of default, I agree to pay costs of collection, including attorney's fees.

I give my permission for messages on my answering machine/voicemail regarding:
 Personal Healthcare Yes No Appointments Yes No

Signature _____

Date _____