Welcome to Hearing Solutions, PLLC .

Please fill out this form as completely as possible. If you have any questions or need assistance, please ask us.

Patient Information: Today's Date: ______________________

Patient's Full Name: ____Preferred Name:____________________

Address: ____ City: ___________________ State: ____Zip: _______

Gender: M / F Date of Birth:__________________ Age:_____ Email____________________________________

Home Phone: ____________________ Cell Phone: ____________________Work Phone:___________________

Referral Source:____

Employment Status: _________________Employer:____________________Occupation:____________________
Student? Yes / No If yes, school student attends:____

Marital Status: ___________ Spouse's Name: _________________________ Is spouse a patient here? Yes/ No

Emergency Contact Name:______________________________Address____________________________________
Relationship to Patient:_____________________________ Phone #: ____________________________

Responsible Party Name: ______________________________ Relationship to Patient: ___________________

Address: _______________________________________City:__________________State:______Zip:___________

Phones: Home: _________________ Cell: ________________ Work: ________________________

Primary Care Physician: ____Phone/Fax#:_________________

Address:____

Referring Physician:___________________________ Referring Physicians Phone/Fax #:___________________
Address:____

Would you like us to send a report to your Referring Physician(s) ? Yes / No

Insurance Information:

PLEASE GIVE INSURANCE CARD(S) TO FRONT DESK, TO MAKE A COPY FOR YOUR CHART

Primary Insurance

Insurance Company: ____________________________

Insurance ID #__________ ________________________

Policy holder's name____________________________

Patient's relationship to policy holder______________

Policy holder's birth date: ________________________

Policy holder's gender: M/F Phone #______________

Address:_____________________________________

Secondary Insurance

Insurance Company: ____________________________

Insurance ID #__________ ______________________

Policy holder's name____________________________

Patient's relationship to policy holder_____________

Policy holder's birth date: ________________________

Policy holder's gender: M/F Phone #_____________

Address:_____________________________________

Copays are due at scheduled appointment.

RELEASE OF INFORMATION STATEMENT

I hereby authorize release of information to appropriate insurance company(ies) and referring doctors that I have requested above. I acknowledge assignment of insurance payments for services rendered to Hearing Solutions, PLLC. I understand that I am financially responsible for all charges incurred for treatment including copays and deductibles for the above named patient that is not covered by the insurance company (ies) listed above. I have read and reviewed the Patient Privacy Statement Policy.

Patient's Signature:_______________________________ Date:_____/_______/______
or Parent/ Legal Guardian