Horizon Audiology, Inc.

PATIENT INFORMATION

Whom may we thank for referring you? Dr. _____ , Friend/Relative, Insurance Plan, Yellow Pages, Website, Other: _____

Patient Name: _____ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ☐ S ☐ M ☐ Sep ☐ W ☐ D Spouse/Partner's Name:

Email: _____

Employer: _____ Occupation: _____

Primary Physician: _____ Phone: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PATIENT INFORMATION

Primary Insurance: _____ Effective Date: _____

Address: _____ Phone: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Place of Employment: _____

Relationship to Patient: _____ Policy Number: _____ Group Number: _____ Co-pay: _____

Secondary Insurance: _____ Effective Date: _____

Address: _____ Phone: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Place of Employment: _____

Relationship to Patient: _____ Policy Number: _____ Group Number: _____ Co-pay: _____

I understand that I am financially responsible for payment of service to Horizon Audiology Inc. I request that payment for authorized insurance benefits and/or Medicare benefits be made to me or on my behalf to these doctors. I authorize any holder of medical information to release to the appropriate agents any information needed to determine these benefits payable for related services. A copy of my signature is as good as the original. Our practice is committed to securing the privacy of your health information. Accordingly, we have available for you to read our Notice of Privacy Practices. You do not have to read this. We would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practice.

Signature: _____ Date: _____