



## 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		CITY	STATE	ZIP
				PHONE

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 \_\_\_\_\_