ALL EARS AUDIOLOGY, INC.

## PATIENT INFORMATION

NAME: _____
(FIRST) (MIDDLE) (LAST) (NICKNAME)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME PH: (  ) _____ - _____ WORK PH: (  ) _____ - _____ CELL PH: (  ) _____ - _____

BIRTHDATE: _____/_____/_____ GENDER: M _____ F _____ MARITAL STATUS: _____

REFERRING PHYSICIAN: _____ PHONE: _____

EMPLOYER NAME: _____ OCCUPATION: _____

## INSURANCE INFORMATION

### PRIMARY

INSURANCE NAME: _____ POLICY HOLDER: _____

ID # _____ GROUP # _____ DOB: _____

### SECONDARY

INSURANCE NAME: _____ POLICY HOLDER: _____

ID # _____ GROUP # _____ DOB: _____

### TERTIARY

INSURANCE NAME: _____ POLICY HOLDER: _____

ID # _____ GROUP # _____ DOB: _____

## RELEASE OF INFORMATION

**INSURANCE ELIGIBILITY GUARANTEE**: I understand that if the above health insurance information provided by myself is not true or if I am not eligible under the terms of the Medical Subscriber Agreement, I am responsible for any and all charges for service rendered. Also if I am not eligible for health insurance coverage, I agree to pay in full for all services rendered within thirty (30) days of receiving a bill from the provider office.

**RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS:** I hereby authorize and direct my insurance company to pay directly to All Ears Audiology, Inc. any benefits due to me and under my insurance plan, including deductibles and co-payments. I also authorize the release of any medical information required for treatment or billing purposes.

_____ _____ _____
SIGNATURE OF PATIENT AND/OR RESPONSIBLE PERSON RELATIONSHIP DATE