WRIGHT AUDIOLOGY AND HEARING AIDS
We're Wright Hear When You Need Us

816-322-8883
Wright Audiology and Hearing Aids *Fax: 816-322-8889*
www.wrighthear.com **8424 Clint Dr. – Belton, MO 64012**

First Name _____ MI _____ Last Name _____
Street Address _____
City_____ State _____ Zip _____
Home Phone _____Cell Phone_____ Work_____
Date of Birth _____ Age _____ Gender: _____
SSN _____ Employer_____
Marital Status _____ Email address _____
Spouse's Name _____
Parent's Name(s) (if pt. is under 18) _____
Primary Care Physician _____ Phone # _____
ENT Physician _____ Phone # _____
Emergency Contact _____ Phone # _____
How did you hear about Wright Audiology and Hearing Aids? (Please check one
_____ Mail _____ Yellow Pages _____ Newspaper _____ Online _____ Insurance: _____
_____ VA _____ Other: _____ Physician: _____

Primary Insurance _____
Primary Cardholder _____ Birthdate_____ Relationship_____
Primary Cardholder's Employer _____ Social Security #: _____
Address of Cardholder if Different from Patient _____ Secondary Insurance
_____
Secondary Cardholder _____ Birthdate_____ Relationship_____
Secondary Cardholder's Employer _____
Address of Cardholder if different from patient _____

Authorization to Release Information
I authorize Wright Audiology and Hearing Aids to release any information obtained during the course of my treatment to the primary care or referring physician listed or to a referred physician for continuity of care.

Patient Signature: _____ Date: _____

Notice of Privacy Practices
I have received and had opportunity to review a copy of the Notice of Privacy Practices for Wright Audiology and Hearing Aids

Patient Signature: _____ Date: _____

Medicare and Third Party Payers
I authorize and assign the payment of all medical benefits to which I am entitled, including Medicare and other health insurance payments, to Wright Audiology and Hearing Aids. I understand that I am financially responsible for payment of any services rendered to me by Wright Audiology and Hearing Aids. Payment is due at the time services are provided unless other payment plan(s) have been set up. I authorize the release of medical record information to secure payment for services rendered.

Patient Signature: _____ Date: _____

Marketing
Wright Audiology and Hearing Aids may contact me regarding benefits or service that may be of interest to me.
____ Yes ____ No

Patient Signature: _____ Date: _____