PATIENT INFORMATION FORM

PATIENT'S NAME (LAST) _____ (FIRST) _____ (M.I.) _____

ADDRESS _____ CITY _____ STATE _____ ZIP_____

PRIMARY PHONE# _____SECONDARY PHONE# _____ SEX: Male or Female (please circle)

Do you have text messaging? (YES or NO) May we contact you via text? (YES or NO) E-MAIL:_____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____

MARITAL STATUS: (CIRCLE ONE): Single Married Divorced Widowed

EMPLOYMENT STATUS: Retired Not Employed Employed Full Time Employed Part Time Self Employed

STUDENT STATUS: Full Time Part Time Not A Student

NAME OF CONTACT PERSON _____
(If other than patient) (Name) (Relationship) (Phone #

HOW DID YOU HEAR ABOUT US (CHECK ALL THAT APPLY): ( )TV ( ) RADIO ( ) NEWSPAPER ( ) PHYSICIAN
( ) FAMILY ( ) FRIEND ( ) YELLOW PAGES ( ) FACEBOOK ( ) ONLINE/WEBSITE: _____

REFERRING DOCTOR_____
(Name) (Phone)

PATIENT'S PRIMARY CARE DOCTOR / PEDIATRICIAN _____
(Name) (Phone)

NAME OF GUARANTOR (Financially Responsible) _____

PRIMARY MEDICAL INSURANCE

_____
(Policy Holder Name) (Relationship to Patient) (Date of Birth) (Employer)

_____
(Policy Holder Street Address) (City / State / Zip) (Phone #)

SECONDARY MEDICAL INSURANCE

_____
(Policy Holder Name) (Relationship to Patient) (Date of Birth) (Employer)

_____
(Policy Holder Street Address) (City / State / Zip) (Phone #)

IS THIS VISIT COVERED BY WORKERS' COMP?_____NO FAULT_____

IN EMERGENCY WHOM MAY WE CONTACT _____PHONE #_____

I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN THE ABOVE INFORMATION. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM AND REQUEST THAT PAYMENT OF BENEFITS BE MADE TO AUGLAIZE AUDIOLOGY UNLESS MY ACCOUNT HAS BEEN PAID IN FULL. I UNDERSTAND AND AGREE REGARDLESS OF MY INSURANCE STATUS, I AM RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT. I UNDERSTAND THAT IF THIS ACCOUNT IS DELINQUENT MORE THAN 120 DAYS A FORMAL COLLECTION PROCESS WILL BEGIN WHICH COULD INCLUDE ADDITIONAL FEES UP TO $100.00 ADDED TO MY ACCOUNT. I HAVE ACKNOWLEDGED RECEIPT OF AUGLAIZE AUDIOLOGY INC. NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY.

_____ DATE _____
SIGNATURE OF PATIENT OR PARENT OF MINOR