LITTLE ROCK AUDIOLOGY CLINIC, INC.

Audiology • Hearing Aid Sales/Service • Hearing Conservation • Dizziness Evaluations

TODAY'S DATE:_____
PATIENT'S NAME:_____D.O.B._____AGE:_____
ADDRESS:_____ MALE:_____
CITY:_____STATE:_____ZIP:_____ FEMALE:_____
HM PHONE: _____CELL:_____SSN#:_____
E-MAIL:_____
EMERCENCY CONTACT:_____RELATIONSHIP:_____PHONE:_____
REFERRING OR PRIMARY PHYSICIAN:_____CITY:_____
REASON FOR VISIT:_____
WHERE DID YOU HEAR ABOUT US? NEWSPAPER RADIO FRIEND OTHER_____

ADULT PATIENTS

EMPLOYER: _____ WK PHONE:_____
MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED
SPOUSE:_____EMPLOYER:_____WK PHONE:_____

CHILD PATIENTS

SCHOOL:_____CITY:_____
MOTHER:_____EMPLOYER:_____PHONE:_____
FATHER:_____EMPLOYER:_____PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____
NAME OF INSURED:_____ID#:_____GROUP#:_____
SECONDARY INSURANCE:_____
NAME OF INSURED:_____ID#:_____GROUP#:_____

BY MY SIGNATURE BELOW, I UNDERSTAND AND AUTHORIZE THE FOLLOWING:

1. **THIS OFFICE MAY RELEASE ANY AND ALL MEDICAL RECORDS AS REQUIRED TO PROCESS INSURANCE CLAIMS.**
2. **I HEREBY ASSIGN TO THE ABOVE ALL INSURANCE PAYMENTS OTHERWISE PAYABLE TO ME.**
3. **I ACKNOWLEDGE FINANCIAL RESPONSIBILITY AND UNDERSTAND THAT I WILL BE RESPONSIBLE TO THE ABOVE FOR ALL COPAYS AND OTHER CHARGES/PROCEDURES NOT PAID BY MY INSURANCE.**

SIGNATURE OF RESPONSIBLE PARTY: X_____

(A COPY OF THE ABOVE WILL BE CONSIDERED AS VALID AS THE ORIGINAL)