

**CARY AUDIOLOGY ASSOCIATES, PLLC**

**PATIENT INFORMATION**

Mr.  Mrs.  Ms.  Dr.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell phone \_\_\_\_\_ Email Address \_\_\_\_\_

Address \_\_\_\_\_

Street Apt. # City State Zip

Spouse's Name \_\_\_\_\_ Daytime Telephone \_\_\_\_\_

In case of emergency, notify: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ Phone \_\_\_\_\_

Would you like us to send results to this physician? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**If patient is under the age of 18, please provide:**

Father's name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Work phone \_\_\_\_\_

**POLICYHOLDER'S INFORMATION**

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ DOB \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ DOB \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

**ASSIGNMENT OF BENEFITS – RELEASE OF INFORMATION**

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to Cary Audiology Associates, PLLC. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment.

\_\_\_\_\_  
**Patient/Parent/Guardian Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

I, \_\_\_\_\_ hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.

\_\_\_\_\_  
**Signature of patient or responsible party**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**