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**