PATIENT INFORMATION SHEET

Please print the information requested on this sheet. Return the sheet to the receptionist with your insurance card(s). Thank you

Name (First, Middle, Last) _____

Street Address _____

Mailing Address _____

City, State, Zip _____

Home/Cell Phone_____ Work Phone _____

Email Address: _____

Date of Birth _____

Emergency Contact _____ Phone # _____ Relationship _____

Primary Care Physician/Referring Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone _____ Office Fax _____

INSURANCE INFORMATION

Insured's Name _____ Insured's DOB _____

Primary Insurance Co. _____ Policy # _____ Group # _____

Secondary Insurance Co. _____ Policy # _____ Group # _____

Assignment of Benefits: (Authorization to pay and release information)
I hereby authorize all benefits to be paid to American Ear Hearing & Audiology, Inc. for the charges for the examination and/or treatment received by me or my dependents. I hereby authorize benefit payers to release any and all information necessary to process any claim for examination and/or treatment received by me or my dependents. I also grant permission to release my or my dependent's records to our physicians. Verification of insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

Signature: _____ Date:_____