Patient Information

*Please print in blue or black ink.

First Name__________________ Middle Initial______ Last Name__________________

Address (Street) ____

City: __________________________ State:__________ Zip:__________________

Home Phone: ________________ Work Phone: ______________ Cell:________________

Birth Date: __________________ Age:___________ Male: ______ Female:______

Social Security #: ______________________ Patient's Occupation: ______________

Employer__________________________________

Marital Status: Married ____ Divorced ____ Single ____ Separated ____ Widowed ____

Spouse's Name:_______________ Parent's Name(s) (if child is under 18)_______________

Referred by: ____

Primary Physician: ________________________ Phone #: ____________________

Emergency Contact: ________________________ Phone #: ____________________

How did you hear about Better Hearing and Balance Connection (check one):

________Referred by Physician (Name) ________ Referred by Friend (Name) _______ Online

________Newspaper Ad (Name) ________ Telephone Book (Name) _______Other

Insurance Information (Please Submit copies)

**This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claims.

Primary Insurance: ____

Address:____

Phone #: ____________________ Group ID #: _________________ Insurance ID #: ____________

Primary Cardholder: ____________________ Birthdate: ____________ Relationship: ___________

Primary Cardholder's Employer: ____________________ Social Security #:____________________

Address of Cardholder if Different from Patient: ____

Secondary Insurance: ____

Address:____

Phone #: ____________________ Group ID #: _________________ Insurance ID #: ____________

Primary Cardholder: ____________________ Birthdate: ____________ Relationship: ___________

Primary Cardholder's Employer: ____________________ Social Security #:____________________

Address of Cardholder if Different from Patient: ____

Signature Authorization

Better Hearing and Balance is a privately owned company and all scheduling and billing will be conducted through the corporation. I authorize direct payment of any medical benefits for service performed at Better Hearing and Balance be sent directly to the office. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. Better Hearing and Balance Connection will be happy to assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included in my plan. It is also my responsibility to contact my insurance carrier to determine if Better Hearing and Balance Connection is in my specific network.

I authorize Better Hearing and Balance Connection to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may be necessary.

I understand that it is my responsibility to notify Better Hearing and Balance Connection if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" fee for which I will assume responsibility. I also permit a copy of this authorization to be used in place of the original. I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Signature: ____ Date: ____________________