EASTSIDE AUDIOLOGY
HEARING EXPERTS. SOUND ADVICE.

Patient Information Form

Last Name _____ First Name _____ MI_____

Birth Date _____ Sex___ Home Phone_____ Cell#_____

Work # _____ E-mail_____

Mailing Address (Street)_____

City_____ State_____ Zip Code_____

Employed By_____

Occupation (or Previous Occupation)_____

Family Relation's Name_____ Work Phone#_____

Nearest Relative not living with you_____ Phone#_____

Emergency Contact Name (Required)_____ Phone#_____

How did you hear about us?_____

Physician (Primary care) Name_____ Phone#_____

Primary Ins._____ Insurance ID#_____

Policy Holder (Subscriber)_____ Policyholder date of birth_____

Secondary Ins_____ Insurance ID#_____

Policy Holder Name_____ Date of Birth_____ Relation_____

Who is financially responsible for this visit?_____ Phone#_____

Relationship to patient_____

Though we file insurance claims as a courtesy to our patients, all charges are ultimately the responsibility of the patient/guarantor. Codes bill for hearing testing services including office visits not covered by insurance will be the responsibility of the patient/guarantor. I have read and understand this policy.

Signature_____ Date_____
(Patient signature, Parent sign if minor)

I authorize Eastside Audiology to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services or products rendered. I understand that quoted insurance benefits are often incomplete or inaccurate. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. I will notify Eastside Audiology of any changes in my health status or in the above information.

Signature_____ Date_____
(Patient signature, Parent sign if minor)