ABLE HEARING
An AudiologyHQ Company

PATIENT INFORMATION

PATIENT NAME FIRST	MIDDLE	LAST	AGE	BIRTH DATE
ADDRESS			SEX	
CITY	STATE	ZIP	MARITAL STATUS S☐ M☐ D☐ W☐	
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL	
EMPLOYER			OCCUPATION	
SPOUSE NAME (IF APPLICABLE)		BIRTH DATE	EMPLOYER	
REFERRING DOCTOR		PRIMARY PHYSICIAN		

ACCOUNT INFORMATION

RESPONSIBLE PARTY FIRST	MIDDLE	LAST		BIRTH DATE
MAILING ADDRESS				SOCIAL SECURITY
CITY	STATE	ZIP	RELATIONSHIP TO PATIENT	
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL	
EMPLOYER		EMPLOYER ADDRESS		

MEDICAL INSURANCE INFORMATION

PRIMARY INS.	INS. COMPANY NAME	ADDRESS	CITY	STATE
SUBSCRIBER'S NAME	BIRTHDATE	EMPLOYER (IF GROUP COVERAGE)		
ID NO.	GROUP NO.	CLAIM NO. (IF MVA OR WORKERS COMP)		
OTHER INS.	INSURANCE COMPANY	I.D. NO.	GROUP NO.	
SUBSCRIBER'S NAME	BIRTHDATE	EMPLOYER		

EMERGENCY CONTACT

NAME				RELATIONSHIP
ADDRESS	CITY	STATE	ZIP	PHONE

I authorize release of medical information to my insurance company or third party payer for billing. I also authorize payment directly to Mid-Valley Hearing Center. A quoted insurance benefit is not a guarantee of payment. I understand that I am financially responsible to Mid-Valley Hearing Center for all charges not covered by insurance. In the event of default, I agree to pay costs of collection, including attorney's fees.

I give my permission for messages on my answering machine/voicemail regarding:
Personal Healthcare ☐ Yes ☐ No Appointments ☐ Yes ☐ No

Signature _____ Date _____