NORTHWEST AUDIOLOGY
and hearing aid center

Welcome to our office. Please complete the following information and sign where indicated.

TODAY'S DATE:_____

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:_____ DOB:_____

MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHYSICAL ADDRESS (If difference than mailing):_____

CELL PHONE:_____ HOME PHONE:_____

EMAIL: _____ SSN (VA Patients Only): _____

OCCUPATION:_____

EMPLOYER:_____ WORK PHONE: _____

ALTERNATE CONTACT:_____

RELATIONSHIP TO PATIENT:_____ PHONE:_____

PRIMARY CARE PHYSICIAN:_____

CLINIC NAME AND LOCATION:_____

HOW DID YOU HEAR ABOUT US?_____

PARENT or GUARDIAN *(Under 18 Only)*

MOTHER'S NAME:_____ PHONE:_____

FATHER'S NAME:_____ PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE PROVIDER:_____

INSURED NAME:_____ INSURED DOB:_____ RELATIONSHIP:_____

SECONDARY INSURANCE PROVIDER :_____

INSURED NAME:_____ INSURED DOB:_____ RELATIONSHIP:_____

AUTHORIZATION TO RELEASE INFORMATION and ASSIGNMENT OF BENEFITS

Do you authorize this office to discuss you or your child's care with any party other than yourself? ____ Yes ____ No

If so, please list them here: _____

I authorize payments of medical benefits to the provider for service rendered or to be rendered in the future without obtaining my signature on each claim submitted. Insurance is a contract between you and your insurance company. It is your responsibility to know the requirements and stipulations of your policy. Some services may not be covered by benefits under your insurance plan. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered. I authorize my insurance benefits to be paid directly to Northwest Audiology & Hearing Aid Center. I authorize Northwest Audiology & Hearing Aid Center to disclose my medical/protected health information for the purpose of my hearing healthcare and treatment, billing, and/or insurance related information.

_____

Signature of Patient or Guardian Date