Hearing & Balance Clinic

Patient Information

For Office Use Only
Scanned: _____
Processed By: _____
Provider: _____

Please complete this form. Attach copies of any additional information or reports that might assist our evaluation

Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____
Street/PO BOX City State Zip Code

Email: _____ Cell Phone: _____ Home Phone: _____

Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ None

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor Student: ☐ Yes ☐ No

May we contact you regarding your appointment at any of the phone numbers or address listed above? ☐ Yes ☐ No

May we contact anyone else regarding your personal health information? ☐ No ☐ Yes, please list below:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Referred By: _____

ENT: _____ Phone Number: _____

Primary Physician: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____
Name Relationship to patient

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

First Name: _____ MI: _____ Last Name: _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ Phone Number: _____ Email: _____

Insurance Information

Primary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____ Relationship to Patient: _____

Member ID #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder: _____

Policy Holder DOB: _____ Relationship to Patient: _____

Member ID #: _____ Group #: _____

Our office will file your insurance for today's visit on your behalf; However, Non-Covered Office Visits, Co-Pays and deductibles are due at the time of visit. Some insurance companies require prior authorization and/or Physician referral. If you are uncertain about your coverage, please inquire with your insurance carrier. I authorize the release of medical information to process any claims to the insurance carrier or third-party payors for reimbursement as well as any health care professionals requesting information for consultation. I authorize payments of medical benefits to ACHS, Inc.

Signature: _____ Date: _____