

WELCOME

NEW JERSEY AUDIOLOGY & HEARING AID CENTER

PATIENT INFORMATION

DATE _____ HOME PHONE _____

PATIENT _____
(LAST) (FIRST) (MI)

RESPONSIBLE PARTY (if minor) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SEX F M AGE _____ BIRTHDATE _____ SINGLE MARRIED WIDOWED DIVORCED SEPARATED

PATIENT EMPLOYED BY _____

BUSINESS ADDRESS _____

OCCUPATION _____ BUSINESS PHONE _____

SPOUSE (OR RESPONSIBLE PARTY) NAME _____ BIRTHDATE _____

BUSINESS NAME & ADDRESS _____

OCCUPATION _____ BUSINESS PHONE _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP _____

PATIENT'S SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY #(if responsible) _____

DO YOU HAVE MEDICAL INSURANCE? YES NO IF YES,

NAME OF PRIMARY INSURANCE _____

CONTRACT # _____ GROUP # _____

NAME OF SECONDARY INSURANCE _____

CONTRACT # _____ GROUP # _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

**** If you would like to sign a release form for us to discuss your history with friends or family let the Receptionist know. Thank you. ****

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____

(NAME OF INSURANCE COMPANY)

AND ASSIGN DIRECTLY TO **NEW JERSEY AUDIOLOGY** ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE **NEW JERSEY AUDIOLOGY** TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE OF INSURED/GUARDIAN DATE _____

SOME HELPFUL INFORMATION

*****WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE?_____*****