FAMILY AUDIOLOGY ASSOCIATES, INC.

Please Print Clearly, in blue or black INK

PATIENT INFORMATION

First Name: _____Middle Initial:_____ Last Name: _____
Address: _____
City:_____ State_____ Zip _____
Home Phone: _____ Work Phone: _____ Cell: _____
Date of Birth: _____ Age: _____ Male ☐ Female ☐
Social Security #: _____ Patient's Occupation: _____
Employer: _____ Is Patient full-time student: Yes ☐ No ☐
Marital Status: Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐
Spouse's Name:_____ Parent's Name(s) (if pt is under 18) _____
Referred by: _____
Primary Physician: _____ Phone: _____
Ear, Nose, Throat Specialist: _____ Phone: _____
Emergency Contact: _____ Phone: _____
How did you hear about Family Audiology Associates, Inc. (Please check one):
☐ Referred by Physician ☐ Referred by Friend _____ ☐ Radio Ad (name) _____
☐ Newspaper Ad (name)_____ ☐ School ☐ Yellow Pages ☐ Online ☐ Other _____

INSURANCE INFORMATION (please submit copies)

Primary Insurance: _____
Address: _____
Phone#:_____Group#: _____ ID#_____
PrimaryCardholder:_____Birthdate:_____ Relationship: _____
Primary Cardholder's employer: _____ Social Security #: _____
Address of Cardholder if Different from Patient: _____

Secondary Insurance: _____
Address: _____
Phone #: _____ Group#: _____ ID# _____
Primaryardholder: _____Birthdate:_____ Relationship: _____
Primary Cardholder's employer: _____ Social Security #: _____
Address of Cardholder if Different from Patient:_____

SIGNATURE AUTHORIZATION

Family Audiology Associates, Inc. is a privately owned company and all scheduling and billing will be conducted through the corporation. I authorize direct payment of any medical benefits for services performed at Family Audiology Associates, Inc., be sent directly to the Celina office. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. Family Audiology will be happy to assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan. It is also my responsibility to contact my insurance carrier to determine if Family Audiology Associates, Inc is in my specific network.

I authorize Family Audiology Associates, Inc. to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.

I understand that it is my responsibility to notify Family Audiology Associates, Inc. if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" fee for which I will assume responsibility.

I also permit a copy of this authorization to be used in place of the original.

I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.
(Medicare beneficiaries)

Signature Date