

Patient Demographic Information

Date _____

Last Name _____ First _____ Middle _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Age: _____ Gender: Male Female Email: _____

Marital Status: Single Married Divorced Social Security Number: _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Physician _____ How did you hear about us? _____

Insurance Information

Responsible party (the name insurance is issued under)

Last Name: _____ First: _____ Middle : _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Work Phone _____ Cell: _____

Relationship to Patient _____ Social Security # _____

Employer's Name _____

Does your health insurance offer a hearing aid benefit? Yes No

I hereby authorize Advanced Audiology Concepts, Inc. to submit claims for payment to my insurance company for payment. I request that payment of authorized benefits be made on my behalf to Advanced Audiology Concepts, Inc. for any service furnished to me. I authorize release of information about me to insurance companies if needed to determine payment for related services. I understand that I am responsible for balances such as co pays, deductibles and co-insurance amounts, as well as charges for uncovered services and/or products.

Signature X _____ Date _____

Signature X _____ Date _____

Signature X _____ Date _____

Signature X _____ Date _____

Signature X _____ Date _____

Signature X _____ Date _____

Acknowledgement of Receipt of Privacy Practices Notice:

Patient Name: _____

Yes, I have been offered a hard copy of the Privacy Practices for my records

I give permission to Advanced Audiology Concepts to discuss issues related to my hearing, hearing instruments and other private health information with the following individual/s:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

X _____
 Patient's Signature

 Date

 Witness Signature

 Date