PROFESSIONAL HEARING AID CENTER

PLEASE TAKE THESE COMPLETED FORMS, DRIVERS LICENSE AND INSURANCE CARDS TO THE FRONT DESK.

PATIENT INFORMATION

Last Name _____ First Name _____ Sex: M _____ F _____

Age _____ Birthdate _____

Address_____ City _____ State _____ Zip _____

Telephone _____ Alternate Telephone _____

E-mail Address _____

Emergency Contact _____ Phone _____

Whom may we thank for this referral? Please check all that apply:

Family/Friend ____ Lakeshore ENT ____ Phonebook ____

Close to home/work ____ Newspaper ____ Website ____ Other ____

BILLING AND INSURANCE INFORMATION

Person responsible for bill (not insurance company) _____ Birthdate _____

Address if different from above _____

Do you have insurance that covers hearing aids? YES NO

If yes, Name of Insurance _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Policy Number: _____

Relationship to Patient: Self _____ Spouse _____ Dependent _____

Are you covered by a secondary insurance? YES NO

If yes, Name of Insurance _____

MEDICAL HISTORY (circle all that apply)

Diabetes High Blood Pressure Cancer/Skin Cancer HIV/AIDS

Hepatitis Allergies Stroke Kidney Disease

Vision Problems Hand Dexterity