Patient Name: Last ___________________________________ First ___________________________ Middle ______________

Social Security #: ________________________ DOB ________________ Sex: _____ Marital Status: _______ Race: _______

Home Address: Street: ____Apt: __________ Ethnicity*: _______________

City/ State: __________________________________ Zip Code: ______________ Language*: ______________

Do you reside in a skilled nursing facility? (Please circle answer) No Yes, where __________________________________

Home Phone #: ____________________________ Work #: ______________________ Cell #: __________________________

Occupation: ____________________________________ Employer: ____

Primary Care Physician and Phone number: ____

Responsible Party (If child): ___________________________________ Relation to Patient: ____________________________

Home Address: Street: ____ Apt: ______________________________

City: ____ State: _______________ Zip Code: ______________

Social Security #: ____________________________ DOB: ________________ Sex: M / F Marital Status: M / S / W / D

Home Phone#: _____________________________ Work #: ______________________ Cell #: __________________________

Primary Insurance Company: _____________________________________ Phone #: __________________________________

ID #: ____ Group #: ________________ Co-pay $: _________________________

Subscriber: _______________________________________ Relation to Patient: ______________________ DOB: ____________

Secondary Insurance Company: ___________________________________ Phone #: _________________________________

ID #: ____ Group #: __________________________

Subscriber: _______________________________________ Relation to Patient: ______________________ DOB: ____________

How did you hear about our practice?

____ Doctor, name ____

____ Friend, whom we may thank ____

____ Insurance company _____ Newspaper Ad _____ Website _____ Other

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I hereby authorize Alexandria Hearing Centers, Massa & Associates and/or Associates in Otolaryngology to apply for benefits from Medicare and any other insurance carrier and payment is to be made directly to Alexandria Hearing Centers, Massa & Associates and/or Associates in Otolaryngology. I certify that the insurance information I reported is correct. In order to determine benefits for which I may be entitled, I further authorize the release of any information, including medical, acquired in the course of my examination or treatment. I also consent to the usage of a copy of this authorization in place of the original. This authorization may be revoked at any time by me or my insurance carrier if a request is submitted in writing. Responsibility for payment of this account remains with the patient regardless of insurance coverage. Patient will also be held responsible for any collection or attorney's fees incurred.

I have received a copy of the Privacy Practices, please initial ___________

DATE: ______________________ SIGNATURE: ____

*** We are required by Federal Regulations to ask for this information, you are not required to answer.**