Colorado Tinnitus and Hearing Center, Inc.

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Connecting People with the Sounds of Life

PATIENT INFORMATION FORM

Last Name_____ First_____ MI_____

Sex_____ Date of Birth_____ Home Phone_____ Cell Phone_____

Mailing Address_____

City_____ State_____ Zip Code_____

Email Address_____

Employed By_____

Spouses Name_____ Cell Phone _____

Nearest Relative not living with you_____ Phone _____

Whom may we contact in case of an Emergency? _____Phone_____

Whom may we thank for referring you to our office?_____

Primary Insurance Company_____ ID#_____

Name of Policy Holder_____ Policy holders date of birth_____

Secondary Insurance Company_____ ID#_____

Who is financially responsible for this bill?_____ Phone _____

I will pay today by CASH_____ CHECK_____ MASTERCARD_____ VISA_____

I authorize Colorado Tinnitus and Hearing Center, Inc.to release information requested with regards to processing my insurance claims.

I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. If you are having a hearing test today - we will collect your specialist copay, and submit the balance to your insurance company for coverage; if they deem you have an additional responsibility, you will be billed for the balance of the invoice 30 days after submission. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I will notify Colorado Tinnitus and Hearing Center, Inc. of any changes in my health insurance status or in the above information.

Signature:_____ Date_____

Parent Signature if Minor_____ Date_____