



Colorado Tinnitus and Hearing Center, Inc.

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Englewood, Colorado 80113
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www.helpforringing.com

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 understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for and professional services rendered. I have read all the information on this sheet and certify that this information is correct to the best of my knowledge. If I do not provide the correct insurance information, I understand I will be responsible for the entire amount of services rendered, upon rejection/denial of payment from my insurance company. 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 _____