Vegas Valley Hearing

Hearing Aids ● Hearing Protection ● Audiology

PATIENT INFORMATION

Date_____Patient name_____

SSN_____☐ Male ☐ Female DOB_____

Address_____

City_____State_____Zip_____

Home Phone_____Work Phone_____

Email address_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Other

Parent name (if patient is a minor)_____

Employer_____Occupation_____

Address_____

Emergency contact?_____Phone_____

Whom may we thank for referring you? _____

PRIMARY INSURANCE

Ins. Co. Name_____

Phone_____Policy#_____Group#_____

Ins. Co. Address_____

Street City State Zip

Insured's Name_____Insured's SS#_____

DOB_____Relationship to patient_____

Insured's Employer_____Employer's Phone_____

SECONDARY INSURANCE

Ins. Co. Name_____

Phone_____Policy#_____Group#_____

Ins. Co. Address_____

Street City State Zip

Insured's Name_____Insured's SS#_____

DOB_____Relationship to patient_____

Insured's Employer_____Employer's Phone_____

FINANCIAL RESPONSIBILITY AND INSURANCE ASSIGNMENT

I hereby apply for treatment by the above audiologist. I accept responsibility to pay for all services rendered on my behalf. In the event of default on any payments due, I agree to pay all costs of collection including attorney's fees.

This will authorize the filing of any insurance in force and the direct payment to Vegas Valley Hearing of any amounts due on my claim under the above stated policy (policies). I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Vegas Valley Hearing for any fees not covered by my insurance. I hereby authorize Vegas Valley Hearing to release any information acquired in the course of the examination to the above stated insurance company(ies).

_____ _____

Signature of patient or parent if minor Date