Lisa C. Predmore, Au.D., P.C.

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Manhasset, New York 11030
(516) 627-7600
(516) 627-6378 fax

audiooffice@optimum.net
www.drpredmore.net

PATIENT INFORMATION

NAME _____

ADDRESS _____

_____

TELEPHONE (home)_____

(work)_____

(cell/other) _____

LOCATION: M Other_____

Co pay_____ Referral Needed_____

DOB: _____

SOCIAL SECURITY #: _____

REFERRAL: _____

DOCTOR: _____

ADDRESS: _____

_____

PRIMARY INSURANCE: _____

NAME OF INSURED: _____

EMPLOYER: _____

RELATIONSHIP: _____

DOB: _____

POLICY #: _____

GROUP #: _____

SECONDARY INSURANCE: _____

NAMED OF INSURED: _____

EMPLOYER: _____

RELATIONSHIP: _____

DOB: _____

POLICY #: _____

GROUP #: _____

I request that payment of authorized Medicare Benefits and/or any other insurance carrier benefits be made either to me or on my behalf to Lisa C. Predmore, Au.D., P.C. for services furnished to me by the Audiologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patients Signature: _____ Date: _____

Audiologist's Signature: _____ Date: _____