

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 #: _____

Email Address: _____

Primary Care Physician and Phone number: _____

Emergency Contact (required): _____ Phone# _____

Responsible Party (If child): _____ Relation to Patient: _____

Home Address: Street: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

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

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.