NORTH SIDE
AUDIOLOGY GROUP, INC.

PATIENT INFORMATION

(CIRCLE) MR. MRS. MS. MALE/FEMALE ADULT/CHILD

NAME: FIRST _____ **LAST:** _____

STREET ADDRESS: _____**CITY** _____

STATE: _____ **ZIPCODE:** _____ **DATE OF BIRTH:** _____

HOME PHONE: ( ) _____ **CELL PHONE: ( )** _____

BEST CONTACT PHONE: ( ) _____**EMAIL:** _____

MAY WE CALL AND LEAVE A MESSAGE AND/OR EMAIL YOU? YES NO

WHAT IS THE REASON FOR TODAY'S VISIT? _____

_____

WHO MAY WE THANK FOR YOUR REFERRAL? _____

_____

PHYSICIAN NAME: _____ **PHONE:** _____

REFERRING PHYSICIAN NAME: _____ **PHONE:** _____

INSURANCE COMPANY NAME: _____

POLICY NUMBER _____**GROUP NUMBER** _____**EFFECTIVE DATE**_____

SUBSCRIBER NAME _____ **RELATIONSHIP** _____

INSURANCE POLICY HOLDER'S DATE OF BIRTH _____

SECONDARY INSURANCE COMPANY NAME: _____

POLICY NUMBER _____ **GROUP NUMBER** _____**EFFECTIVE DATE**_____

SUBSCRIBER NAME _____ **RELATIONSHIP** _____

INSURANCE POLICY HOLDER'S DATE OF BIRTH _____

EMERGENY CONTACT NAME _____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT PHONE NUMBER _____

WHAT WOULD YOU LIKE TO LEARN FROM TODAY'S VISIT? _____

_____

I authorize my insurance benefits to be paid directly to North Side Audiology Group, Inc. I understand that I am financially responsible for any balance. I authorize North Side Audiology Group or my insurance company to release any information needed to process my claims. I give permission to you and any agent of North Side Audiology Group, Inc. to contact me on any phone number/email that I have provided to you, for the purpose of collecting my debt, appointment reminders and changes. I am aware of this office's Notice of Privacy practices and fully understand my rights as a patient.

_____ _____

Signature Date

Check here _____ if you do not wish to receive occasional mailings from North Side Audiology Group (newsletters, events, etc.)