AUDIOLOGY AND HEARING AID CENTER OF GAINESVILLE

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Patient Information

Patient Name:_____

Date of Birth:_____Age:_____

Address: _____
Street

_____
City *State* *Zip Code*

Parent/Caregiver Name:_____
(if applicable)

Phone: Home_____Cell_____Work_____

Emergency Contact:_____
Name *Phone* *Relationship to Patient*

Email Address:_____

Referred By:_____

Primary Care Physician:_____

How did you hear about us (check all that apply): __ Insurance __ Google __ Website
__ Bull Run Observer__ Dominion Valley ___Lake Manassas __ Heritage Hunt
__ Dunbarton __ Other
__ Patient (who may we thank for this referral): _____

Primary Insurance: _____ ID# _____
Cardholder Name: _____ DOB: _____
Secondary Insurance: _____ ID# _____
Cardholder Name: _____ DOB: _____

In order to keep overhead costs to a minimum, co-pays and payments for services not covered by health insurance are expected at time of appointment. I understand that I am responsible for obtaining appropriate referrals required by my health insurance policy. I understand that I will be financially responsible for any portion of payment not covered by health insurance.

_____ _____
Signature of person responsible for payment Date