BERGER AUDIOLOGY
Your First Choice In Hearing Healthcare

Berger Audiology LLC

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bergeraudiology.com 2930 Miller Drive - Plymouth, IN 46563

Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Other _____

~~Social Security #~~ _____ ~~Social Security # of Guardian (if minor)~~ _____

Mailing Address (Street) _____

City _____ ST _____ ZIP _____

Email Address: _____

CIRCLE ONE: Mr Mrs Miss Ms Dr Father Sister Reverend

How would you like to be addressed? _____

Primary Care Physician (First and Last Name) _____ Phone # _____

Emergency Contact: _____ Phone # _____ Relationship _____

Primary Ins. _____ ~~Insurance ID#~~ _____

~~Name of Policy Holder~~ _____ ~~Policy holders date of birth~~ _____

Secondary Ins. _____ _____ ~~Insurance ID#~~ _____

I will pay today by Cash _____ Check _____ Credit Card _____ Other # _____

I authorize Berger Audiology LLC to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Berger Audiology LLC of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____