JACKSON COUNTY AUDIOLOGY
CHARLES E. HARE, M.S., CCC/A • ROBERTA M. BEILE, M.A., CCC/A

PATIENT INFORMATION FORM

Section I: **Patient Information** **Date_______________**

Name:____ I Prefer to be called: ___________________________

Address:____________________________________City:_________________________State:________Zip_______________

Phone (______)_____________________ Cell Phone (______)______________________

The best time to contact me is: ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_______________ ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Employer______________________ Work Phone__________________ Spouse or Parent's Name: _________________________

How were you referred to our office (name, website, phone directory, etc.)? ____

Person to contact in case of emergency____________________________Relationship______________ Phone_________________

Primary Care Physician: ____ Phone_________________

Email Address____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:__________________________________ Relationship to Patient: ____________________ SN#_______________________

Address:____City:_______________________State:________Zip_______________

Phone: (____)____________________ Employer_________________________ Work Phone (____)__________________

Section III **Insurance Information**

Name of Insured___________________________________DOB_______________Relationship to Patient ____________________

SSN#:________________________ Name of Employer:______________________________ Work Phone: (____)_______________

Address of Employer:___________________________________City_________________________State:________Zip ___________

Primary Insurance Company______________________________________ Grp #__________________ ID#____________________

Ins Co Address:____ Ins Co. Phone:____________________________

------------ **DO YOU HAVE ANY ADDIONAL INSURANCE?** ☐ Yes ☐ No **IF YES, COMPLETE THE FOLLOWING** ------------

Name of Insured___________________________________DOB_______________Relationship to Patient ____________________

SSN#:________________________ Name of Employer:______________________________ Work Phone: (____)_______________

Address of Employer:___________________________________City_________________________State:________Zip ___________

Secondary Insurance Company______________________________________ Grp #_________________ ID#____________________

Ins Co Address:____ Ins Co. Phone:____________________________

AUTHORIZATIONS AND AGREEMENTS

1) I agree the information above is accurate. In addition, if applicable, I hereby grant permission for Jackson County Audiology to release any information necessary to process my insurance claim. I authorize payment of medical benefits (if payment is due) to this office for provided goods and services. *In the event that my insurance does not pay, I understand that I will be responsible for the full amount due.* **INITIALS:______**

SEE BACK PAGE FOR SIGNATURE

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AUTHORIZATIONS AND AGREEMENTS, CONTINUED

2) By initialing this section and signing below, I authorize Jackson County Audiology to send me educational and/or marketing information on products and services offered by their manufacturers and/or product supply companies. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time**.** **INITIALS:** _____

Signature: ____ **Date:** __________________________________

Signature: ____ **Date:** __________________________________

Signature: ____ **Date:** __________________________________

Signature: ____ **Date:** __________________________________

Signature: ____ **Date:** __________________________________

Signature: ____ **Date:** __________________________________

Signature: ____ **Date:** __________________________________

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