



www.premierhearing.com

(For Office Use)
Cycle #:

Please complete the following information.

Patient's Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Patient's First Name	Middle Initial	Last Name
Number and Street	Apt. #	
City	State	Zip Code
Home Telephone	Cell	Work
E-mail Address	Send statements by E-mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Emergency Contact Name	Relation to Patient
Home Telephone	Cell
Work	

Responsible Party (if other than Patient)	Relation to Patient
Number and Street	Apt. #
City	State
Zip Code	
Home Telephone	Cell
Work	
E-Mail Address	Send statements to Responsible Party? <input type="checkbox"/> Yes <input type="checkbox"/> No

Information in this section is needed from insurance patients only.

Otherwise, please continue to next page.

Primary Health Insurance	Secondary Health Insurance	Tertiary Health Insurance
Please provide your insurance card so that a copy can be put in your file.		
Employment Status		
<input type="checkbox"/> Full Time	<input type="checkbox"/> Not Employed	<input type="checkbox"/> Retired
<input type="checkbox"/> Part Time	<input type="checkbox"/> Self-employed	<input type="checkbox"/> Active Military
Employer		Occupation
Student Status		School
<input type="checkbox"/> Not a Student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
Marital Status		
<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
<input type="checkbox"/> Married	<input type="checkbox"/> Partner	<input type="checkbox"/> Legally Separated
Patient's Relation to Insured		
<input type="checkbox"/> Self	<input type="checkbox"/> Child	<input type="checkbox"/> Partner
<input type="checkbox"/> Spouse	<input type="checkbox"/> Parent	<input type="checkbox"/> Other:
Insured's Date of Birth	Gender	Social Security Number
	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Insured's First Name	Middle Initial	Last Name
Number and Street		Apt. #
City		State
		Zip Code
Home Telephone	Cell	Work
E-mail Address		

Patient Name

Referred by: <input type="checkbox"/> Direct Mailing <input type="checkbox"/> Friend <input type="checkbox"/> Online <input type="checkbox"/> Walk-in <input type="checkbox"/> Doctor, Name: <input type="checkbox"/> Insurance Company <input type="checkbox"/> Other Patient, Name: <input type="checkbox"/> Other:
--

Primary Care Physician	Telephone
------------------------	-----------

Number and Street	Suite #
-------------------	---------

City	State	Zip Code
------	-------	----------

Patient's Summer/Winter Address

Number and Street	Apt. #
-------------------	--------

City	State	Zip Code
------	-------	----------

Telephone	At what times of the year do you stay at this other address?
-----------	--

Would you like a report sent to your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no insurance, how will you be paying? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card
--	---

May we call with specials? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we send mail or E-mail with specials? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

I certify that the above information is true and correct to the best of my knowledge. I give permission to the hearing care professional to administer and perform such procedures as may be necessary in the diagnosis and/or treatment of my ears and hearing. I also authorize the release of any information necessary to process claims.

I understand that payment is due at time of service, including any co-pays or charges that are not anticipated to be covered by insurance and that a deposit is required on all new hearing aid purchases. As a courtesy to our patients we will bill your insurance company. However, you or your legal representative will be responsible for payment of all charges that are not fully paid by the insurance plan. I understand that any difference between the charges on my contract and the reimbursement from insurance will be paid by me or my legal representative within 30 days.

We accept cash, check, and major credit cards. Payment plans may be discussed with the Patient Coordinator. Finance charges may be applied to balances outstanding beyond 60 days.

Signature: _____	Date: _____	(For Office Use) Cycle #:
------------------	-------------	------------------------------