FALLS HEARING CENTER

Patient Information Form

Name_____ Preferred Name_____

Date of Birth____/____/_____ Age_____ Sex: M F Patient's SSN_____

Marital Status: ◯ Married ◯ Single ◯ Widowed Spouse/Contact Person_____

Address_____ City_____ State/Zip_____

Home Phone (____)_____ Cell Phone (____)_____ Preferred: home/cell
(Circle one)

Email Address_____

Occupation_____ Employer_____

Primary Physician_____ Town/State_____

Type of Insurance_____

Please give your insurance information to our front office staff so we can make a copy for our records.

How did you hear about our office?

◯ TV (Channel_____) ◯ Newspaper ◯ Internet
◯ Phone Book ◯ Insurance ◯ Health/Senior Fair
◯ Friend_____ ◯ Referred by physician_____

Please read and sign below: I authorize the release of any medical information necessary to process claims submitted by the above named provider. I also authorize payment of government benefits, Medicare benefits or any other medical benefits to the above named provider for all services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature_____ **Date**_____