Hart Hearing Centers

www.HartHearing.com

Patient Information Form

Circle one:
Mr./Mrs./Ms./Dr. Last Name ____________________ First Name ____________________ MI ___________

Birth Date ____________ Sex _____ Home Phone # ________________ Other__________________________

Mailing Address (Street) ____

City __________________________ State_______________ Zip Code _________________________________

Social Security Number ____
(Strictly used for billing purposes)

E-mail Address ____
(E-mail address will never be shared and is strictly used for us to contact you)

Employer ____

Referring Physician ________________________________ Phone # ___________________________

Primary Care Physician _____________________________ Phone # ___________________________

Whom may we contact in case of an emergency? ____________________ Phone #________________________

Primary Insurance Company:

Insurance ID#:

Who is financially responsible for this visit? _________________________ Phone # _____________________

I authorize Hart Hearing Centers to release medical information necessary to process a claim for services. I hereby authorize payment directly to Hart Hearing Centers for services rendered.

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 hereby agree to pay Hart Hearing Centers for all reasonable charges. In the event that I fail to pay charges when due and Hart Hearing Center refers the amount to an attorney for collection, I agree to pay the cost of the collection including the attorney's fees.

Signature ____ Date ____________________

Parent Signature if Minor ____________________________________ Date ____________________