Family Hearing Services

775-738-4227
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Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Cell # _____

Mailing Address (Street) _____

City _____ State_____ Zip Code_____

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

Employed By _____ Work Phone # _____

Physician _____ Physician Phone #_____

Spouse's Name _____

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

Whom may we thank for referring you to our office? _____

Primary Insurance Co. _____ Secondary Insurance Co. _____

Name of Ins. Card Holder _____ Ins. Card holders date of birth_____

Please provide us with your insurance card(s) so that a copy may be filed in your chart.

I authorize Family Hearing Services 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 Family Hearing Services of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____