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Patient Intake Form

Name: ______________________________________Date of Birth: _______________ Age: __________
First MI Last

Address: Social Security #

____

Telephone# _______________ Mobile# __________________ Email_____________________________

Occupation: _________________ Employer: ____
Company Name Address

Spouse Name: _________________________ Spouse Telephone # _____________________________

Spouse Employer: _______________________Spouse Date of Birth:____/___/____ Age: __________

Spouse's Social Security # _______________________ (only needed if spouse is insurance policy holder/or secondary)

Policy Holder:

____

Primary Insurance Co. ____________________________ID# __________________ Grp # ____________

Secondary Insurance Co. _________________________ID# __________________ Grp # ____________

In case of emergency, contact:

____
Name Relationship Phone

Primary Care Physician:

____

Would you like a copy of your test results forwarded to your physician? ___ Yes No *(If so, please sign below)

How did you hear about us? (friend, family, drive by, marketing piece, newspaper)____________

If applicable, please provide the name of the person who referred you to our office: ___________

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim.

Further, I authorize payment of medical benefits to be made directly to Atlas Audiology, PLLC. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_______________________________________ ________________________________
Patient /Parent/Guardian Signature Date