



# AUDIOLOGY ASSOCIATES

661-284-1900

Fax: 661-284-1988

www.AudiologyAssociates.net cs@audiologyassociates.net 23838 Valencia Blvd Suite 100 - Valencia, CA 91355

## Patient Information Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Social Security # \_\_\_\_\_ *Do you wear a pacemaker?* \_\_\_\_\_

Mailing Address (Street) \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Email \_\_\_\_\_ Work.Phone#: \_\_\_\_\_

Relative's Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

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

Whom may we thank for referring you to our office? \_\_\_\_\_

Type of Insurance: Medicare MediCal Private Care Credit HMO Other: \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy holder's date of birth \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Primary Physician? \_\_\_\_\_ Phone # \_\_\_\_\_

I authorize AUDIOLOGY ASSOCIATES 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 AUDIOLOGY ASSOCIATES of any changes in my health status or in the above information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature if Minor \_\_\_\_\_ Date \_\_\_\_\_