Audiology associates
Better Hearing Begins Now!

25425 Orchard Village Rd.
Suite #220
Santa Clarita, 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.

Patient Signature: _____ Date: _____

Parent Signature if Minor: _____ Date: _____