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□ Neuro-Audiology Consultants
□ Miami Hearing and Speech Center
□ Audiology Consultants of Boynton Beach

PATIENT INFORMATION

Name of Patient_____

O Married O Single O Divorced O Widowed

Spouse Name_____ DOB_____

Address_____

City_____ State___ Zip_____

Home#_____ Cell#_____

Work#_____

Email_____

Age_____ Date of Birth_____

Sex O M O F Weight_____

Driver's License No._____

Social Security No._____

Patient Occupation_____

Employer Name_____

Address_____

City_____ State____ Zip_____

Emergency Contact Name (that does not reside with you) Phone

If patient is a minor, please complete this section.

Name of Responsible Party_____

Address_____

City_____ State_____ Zip_____

Mother's Work Phone_____

Mother's Name_____

Address_____

City_____ State_____ Zip_____

Father's Work Phone_____

Father's Name_____

Address_____

City_____ State_____ Zip_____

If parents are divorced, who has legal custody? O Mother O Father O Both O Other

Responsible Party (if other than patient).

Name_____ DOB_____

Address_____

City_____ State_____ Zip_____

Home Phone ( )_____

Work Phone ( )_____

Social Security No._____

Driver's License No._____

Employer_____

Address_____

City_____ State_____ Zip_____

Family Doctor_____

Address_____

City_____ **State**_____ **Zip**_____

Telephone ( )_____**Fax( )**_____

Referred By_____

Address_____

City_____ **State**_____ **Zip**_____

Telephone ( )_____**Fax( )**_____

INSURANCE INFORMATION

Records Release
This must be signed if any insurance is to be filled by you or us.

I hereby authorize Neuro-Audiology Consultants/Miami Hearing & Speech Center/Miami Hearing Aid Center/Audiology Consultants of Boynton Beach to release to my insurance company any information acquired in the course of my examination or treatment.

Signed_____ Date_____

Assignment of Benefits
This must be signed if we are filing to you insurance company for payment

I authorize my insurance company to pay my medical benefits to Neuro-Audiology Consultants/Miami Hearing & Speech Center/Miami Hearing Aid Center/Audiology Consultants of Boynton Beach for services rendered.
I understand that I am responsible for any unpaid balance.

Signed_____ Date_____

Insurance Waiver
This must be signed by (or on behalf of all patients).

I understand that services provided to me may not be a covered benefit as defined by my insurance company. I agree to be personally responsible for payment for the services rendered. I also agree to pay any co-pays and/or deductibles as required by my insurance company.

Signed_____ Date_____

Notice of Privacy Practices
This must be signed by (or on behalf of all patients).

I have been given the opportunity to read and receive a copy of the Notice of Privacy Practices (NPP) of Neuro-Audiology Consultants, Audiology Consultants of Boynton Beach, Miami Hearing & Speech Center & Miami Hearing Aid Center
The NPP provides detailed information about how the practice may use and disclose my confidential information.

The provider reserves the right to change the privacy practices that are described in the NPP. I understand that a copy of any Revised Notice will be provided to me or made available in the office.

Signed_____ Date_____

Primary Insurance Information

Subscriber's Name_____ Insurer_____
Social Security No._____ Address_____
ID#_____Group#_____ City_____ State_____ Zip_____
Date of Birth_____ Phone No.( )_____

Do you have secondary insurance? O Yes O No
If yes, the receptionist needs information regarding your secondary insurance so that your claim can be submitted appropriately.