SHOW LOW
2600 S. White Mountain Rd.
Show Low, AZ 85901
Phone: (928) 537-3456
Fax: (928) 537-3469

Audiology, Inc.
HEARING & BALANCE SERVICES

SAFFORD
620 S Central Ave, Ste B
Safford, AZ 85546
Phone: (928) 428-1613
Fax: (928) 428-0055

PATIENT INFORMATION

First Name: _____ Last Name: _____ MI: ____ Preferred Name: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Phone #: (Home/Cell/Other) _____ Phone #: (Home/Cell/Other) _____
(Circle One) (Circle One)

Birth Date: _____ Sex: M F Age: ___ Are you a Student: Y N Full Time: ___ Part Time: ___ Not a Student: ___

Employment Status: ( ) Employed F/T ( ) P/T ( ) Self Employed ( ) Not Employed ( ) Retired ( ) Active Military

Marital Status: ( ) Married ( ) Single ( ) Partner ( ) Widowed ( ) Divorced ( ) Legally Separated

Adult Social Security #: _____ Soc. Sec. # of Guardian (if patient is a minor): _____

Spouse, Parent, Other: _____ Phone #: _____ Relationship: _____
(Circle One)

Emergency Contact: _____ Phone #: _____ Relationship: _____
(if different than above)

Email Address: _____

Referring Physician: _____ Primary Care Physician (if different): _____

Primary Preferred Contact: ( ) Home # ( ) Cell # ( ) Work # ( ) Email ( ) Text & Cell Provider:_____

How did you hear about us? ( ) Physician's Name: _____ ( ) Friend's Name:_____

( ) Mail ( ) Newspaper ( ) Radio ( ) Insurance ( ) Website ( ) Yellow Pages ( ) Other: _____

Who is financially responsible for this visit?: _____ Phone #: _____
(Self, Spouse or Parent)

Primary Insurance _____ Policy ID Number _____

Name of Policy Holder _____ Group ID Number _____

Relationship of Patient to Policy Holder _____ Policy Holders Date of Birth _____

Policy Holders Employer _____ Employer's Phone # _____

Secondary Insurance _____ Policy ID Number _____

Name of Policy Holder _____ Group ID Number _____

Relationship of Patient to Policy Holder _____ Policy Holders Date of Birth _____

Authorization for service, guarantee of payment, assignment of insurance benefits

1. I give permission to Audiology, Inc. to release information, verbal and/or written, contained in my medical record and other related information to my insurance company, rehabilitation nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.
2. I acknowledge that I have received and reviewed this office's Notice of Privacy Practices (HIPAA) that outlines how patient confidential information will be used, disclosed and protected and what my rights are concerning the information in my health record.
3. I consent to the use and disclosure of my health information for treatment, payment and healthcare options.
4. I have read all the information on this page and on the Financial policy and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Audiology, Inc. permission to treat my concerns.

Patient/Parent or Guardian Signature:_____ Date:_____