Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____

City, State and Zip: _____

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____

Email Address: _____

Employment Status: Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Occupation: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Sex: Male ☐ Female ☐

Referring Physician: _____ Primary Physician: _____

Emergency Contact Name and Phone #: _____

Insurance Information *Please provide receptionist with card(s) so that they may be scanned*

Primary Insurance:

Plan Name: _____ Policy/ID # _____ Group #_____

Subscriber's Name: _____ Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Secondary Insurance:

Company: _____ ID # _____

Patient's Authorization

I authorize PRIORITY HEARING AND BALANCE, LLC to apply for benefits on my behalf for services rendered by PRIORITY HEARING AND BALANCE, LLC I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical records for this or any related claims. I also authorize PRIORITY HEARING AND BALANCE, LLC to collect any payment made by insurance carrier for services rendered and billed by PRIORITY HEARING AND BALANCE, LLC I permit a copy this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for diagnostic testing services and medical devices when a statement is rendered. I understand that I may be charged $35 if 24 hour cancellation notice is not given prior to scheduled appointments.

_____ _____

Signature of Patient or Guardian Date