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*

Prima[illegible]nsuranc[illegible]

[illegible]Nam[illegible] ______________________ P[illegible]cy/ID # ______________________ [illegible]oup [illegible] ________

Sub[illegible]er's Name: ______________________ Patie[illegible]lationship to Subscriber: ______________________

Su[illegible]scri[illegible] DOB: ______________________ Sub[illegible]crib[illegible]mployer: ______________________

Secon[illegible]ary Insu[illegible]e:

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