Greenspan Audiology, PC

PATIENT INFORMATION: This section refers to the patient only.

Name _____Address _____

Home Phone _____ City _____State _____Zip_____

Age _____ Date of Birth _____ Sex _____ Marital Status _____

E-Mail Address _____ SS# _____

Employer _____ Address _____

Work Phone _____ City _____ State _____ Zip _____

BILLING: Please complete if t he person responsible for billing is someone other than patient.

Name _____ Relationship to Patient _____

SS#_____ Address _____

Insured's Date of Birth _____ City _____ State _____ Zip _____

Employer _____ Address _____

Work Phone _____ City _____ State _____ Zip _____

PLEASE GIVE ALL INSURANCE CARD(S) TO SECRETARY FOR COPYING

Workman's Compensation: Yes___ No___

Reason for today's visit _____

Primary Care Physician _____
Address _____ Phone _____

PLEASE SIGN: Patient's signature for the release of medical information.
I authorize the release of information necessary to file a claim with my insurance carrier and request payment of benefits to either self or to the audiologist if fees have not been pre-paid. I understand that I am financially responsible for any balance not offered by my insurance carrier.

Signature _____ Date _____

PLEASE SIGN: Patient's signature for the release of medical information.
I authorize the release of my records to any party I deem appropriate and will allow notification with either a telephone call or a signed form by or from either myself, as a legal guardian to the patient above or as attorney in fact.

Signature _____ Date _____

Patient Name _____