New Patient Information

Date:

Name: _____ Social Security Number: _____

Address: _____ Sex: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Age: _____ Date of Birth: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Phone: _____

If patient is under the age of 18, please give:

Mother's Name: _____ Work Phone: _____

Father's Name: _____ Work Phone: _____

Nearest relative not living with you: _____

Relationship: _____ Phone: _____

Have any family members been seen here? ❒ Yes ❒ No

If yes, his/her name: _____ Phone: _____

Chief complaint: _____

Do you currently wear hearing aids? ❒ Yes ❒ No If so, what type? _____ Year: _____

Primary Insurance:	**Secondary Insurance:**
Name of cardholder:	**Name of cardholder:**
Date of birth if other than patient:	**Date of birth if other than patient:**

How did you hear about us? _____

Primary care doctor: _____ Phone: _____

Do you wish us to send results to this physician? ❒ Yes ❒ No

ASSIGNMENT OF BENEFITS – RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance and any other health plans, to Chattanooga's Healthy Hearing. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payments.

Signature _____

If patient under 18, Guardian's Signature: _____