**Patient Information Form**

Last Name First Name MI\_\_\_\_\_\_

Birth Date: Phone 1 Atl Phone:

Social Security # Email Address:

Mailing Address (Street)

City State Zip Code

If under age 3 – Birth Hospital

Mothers full name Mothers Date of Birth

Employed By

Nearest Family Member Relationship

Primary Care Physician

Whom may we contact in case of an emergency?

Whom may we thank for referring you to our office?

Primary Ins. Insurance ID#

Name of Policy Holder Policy Holder Date of Birth

Secondary Ins. Insurance ID#

Who is financially responsible for this visit? Phone #

I will pay by Cash Check Credit Card Other#

I authorize Trinity Hearing Center to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Trinity Hearing Center of any changes in my health status or in the above information.

Signature Date

Parent Signature if Minor Date