Case History

Today's Date: _____ Patient's Social Security #: _____

Patient's Name: _____ **Sex: M / F DOB:** _____

Parent/Guardian Name (if patient is a child): _____

Address: _____
Street City State Zip

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____

Patient's/Parent's Employer: _____ Occupation: _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Insurance Name: _____

Name of Insured: _____ **DOB:** _____ **SS#** _____

2nd Insurance: _____

Name of Insured: _____ DOB: _____ SS# _____

Primary/PPO Physician: _____
First Last Phone #

If referred, Referring Physician: _____
First Last Phone #

Reason for referral? _____

May we send your doctor a note about your evaluation? ☐ **Yes or** ☐ **No**

Emergency Contact: _____ Relation: _____ Phone: _____

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to All About Hearing, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named may use my healthcare information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____