Greenbrier Audiology, Inc.

PATIENT INFORMATION: This section refers to the patient only.

Name_____ DOB_____ Sex_____

Address_____ SS#_____

City_____ State_____ Zip_____

Home #_____ Cell #_____ Marital Status_____

Employer_____ Employer Ph #_____

Address_____

City:_____ State:_____ Zip:_____

BILLING: Please complete if the person responsible for billing/payment is someone other than the patient.

Name_____ Relationship to Patient: _____ SS# _____

Address_____ Insured's Date of Birth: _____

City_____ State_____ Zip_____ Home #_____

Employer_____ Ph #_____

Address_____ City:_____ State: _____ Zip: _____

PLEASE GIVE ALL INSURANCE CARD(S) & DRIVER'S LICENSE TO SECRETARY FOR COPYING

Have you ever been awarded hearing aids through

Worker's Compensation? Yes _____ No_____

Claim # _____

MOTOR VEHICLE ACCIDENT Yes _____ No_____

INSURANCE CO._____

Claim # _____

Please list below, the name and address of where a report is to be sent.

_____

_____

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 benefits to either myself or to the audiologist if fees have not been pre-paid. I understand that I am financia responsible for any balance not covered by my insurance carrier.

Signature _____ **Date**_____