Patient Information Form

Central Maine Audiology
...we're listening.

Date _____

Patient Name _____ DOB _____ /_____ /_____
First *MI* *Last* *mm* *dd* *yyyy*

Mailing Address _____
Street *City* *State* *Zip*

Alternate Address _____
Street *City* *State* *Zip*

Home Phone _____ Cell Phone _____

Occupation _____ Work Phone _____
(If retired, prior occupation)

Email _____

Preferred Method of Contact: ○ Home Phone ○ Cell Phone ○ Text ○ Email ○ Mail

Gender: ○ M ○ F Marital Status: ○ Married ○ Single ○ Widowed ○ Long-Term Commitment

Spouse/Partner Name _____

Emergency Contact _____ Phone _____

Relation to Patient _____

Primary Care Physician _____

Practice _____ Phone _____

Reason for Appointment _____

Parent/Guardian/POA Information If you are an authorized representative acting on the patient's behalf (i.e. parent, guardian, power of attorney) please complete the following. Please note that you may be asked to provide legal evidence upon request.

CIRCLE ONE: Parent Guardian POA

Responsible Party _____ DOB _____ /_____ /_____
First *MI* *Last* *mm* *dd* *yyyy*

Mailing Address _____
Street *City* *State* *Zip*

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Preferred Method of Contact: ○ Home Phone ○ Cell Phone ○ Text ○ Email ○ Mail

Patient Information Form (cont.)

Health Insurance Information

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Primary Insurance _____ ID Number _____

Subscriber's Name _____ DOB ____/____/____
First MI Last mm dd yyyy

Relation to Patient _____ Contact Number _____

Mailing Address _____
Street City State Zip

Secondary Insurance _____ ID Number _____

Subscriber's Name _____ DOB ____/____/____
First MI Last mm dd yyyy

Relation to Patient _____ Contact Number _____

Mailing Address _____
Street City State Zip

Other Insurance (Workers' Compensation, Liability, etc.):

Name of Insurance Carrier _____ DOB ____/____/____
mm dd yyyy

Employer Name _____ Employer Phone _____

Workers' Comp Case Contact _____ Case Number _____

I certify that, to the best of my knowledge, the above information is correct and true. I do understand that I am ultimately responsible for payment, even if I am here for a Workers' Compensation visit. I understand that I will be billed for any remaining balance after insurance has paid, and that it is my responsibility to pay this remainder. I further understand that if any insurance denies the claim, I will be billed for the entire balance.

_____ _____
Signature of Patient or Authorized Representative *Date*

Other Information

How did you hear about us? ○ Website ○ Employer ○ Sponsored Event ○ Yellow Pages
○ Insurance ○ Mail ○ Newspaper Ad

Whom can we thank for referring you? _____

Is this a: ○ Friend ○ Physician ○ Other: _____