BALANCE and EAR CENTER inc.

Virginia Hearing Center

Patient Information

First Name: _____ MI: _____ Last Name: _____

Address: _____

City, State, Zip code: _____

Phone Numbers | Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Email: _____

Social Security: _____-_____-_____ Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

Referred By: _____ Primary Care Physician: _____

Reason for Visit: _____

RESPONSIBLE PARTY INFORMATION

Primary Insurance Co: _____

Member ID: _____ Group Number: _____ SSN: _____

Policy Holder's Full Name (if not patient): _____

Secondary Insurance Co: _____

Member ID: _____ Group Number: _____ SSN: _____

Policy Holder's Full Name (if not patient): _____

Patient's relationship to policy holder: _____ Date of Birth: _____

I hereby authorize the release of medical information to insurance carriers and/or other physicians, and also for benefits to be paid directly to Balance and Ear Center, Inc. In the care of a minor, I authorize the filing of insurance claims. I understand that I am responsible for all charges (including non-covered charges) arising from the treatment of the named patient. Should this account become delinquent, I agree to pay all collection and court costs, including attorney's fees.

Signature: _____ Date: _____

In case of emergency, please notify:

Name: _____ Phone: _____

IF PATIENT IS A MINOR:

Mother's Name: _____ SSN: _____

Address: _____

City, State, Zip code: _____

Phone Numbers | Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____

Father's Name: _____ SSN: _____

Address: _____

City, State, Zip code: _____

Phone Numbers | Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____) _____-_____