Last Name ______________________________________ First Name __________________________ MI______

Address ____

City ____ State _________________ Zip Code_____________

Date of Birth __________________________________ Sex Male Female Status S M W D

Home Phone __________________________________ Social Security # ___________________________

Cell Phone ____________________________________ Work Phone ___________________________________

Emergency Contact _______________________________________ Phone ______________________________

Referring Physician _________________________________ Your Email ________________________________

Primary Insurance Information

Company __________________________________

Policy Number ______________________________

Group Number ______________________________

Co-Payment ________________________________

Policy Holder _______________________________

Relationship ___________________ DOB ________

Employer ___________________________________

Secondary Insurance Information

Company __________________________________

Policy Number ______________________________

Group Number ______________________________

Co-Payment ________________________________

Policy Holder _______________________________

Relationship ___________________DOB _______

Employer ___________________________________

Guarantor Information

Guarantor Name ____

Address ____

City ________________________________ State _________________________ Zip Code ________________

Phone _______________________________________ Miscellaneous _________________________________

Patient's Authorization

I authorize HEARING PROFESSIONALS, INC. to apply for benefits on my behalf for services rendered by HEARING PROFESSIONALS, INC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical records for this or any related claims. I also authorize HEARING PROFESSIONALS, INC. to collect any payment made by insurance carrier for services rendered and billed by HEARING PROFESSIONALS, INC. I permit a copy this authorization to be used in palace of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

I also agree to abide by HEARING PROFESSIONALS, INC. 24 hour cancellation policy and understand that I may be charged up to $30.00 for notification of less than 24hours.

____ __________________________

Signature of Patient or Guardian Date