*Northwest Florida ENT*

**850-438-8000**
**Fax: 561-848-8001**

**www.audiology.pro eardoc@audiology.pro 123 N. Carson Street - Pensacola, Fl 32502**

**Welcome to our office. Please complete the following information and sign where indicated.**

Please circle one: *Mr.* *Mrs.* *Ms.* *Dr.* Patient Name: *Robert L. Smith*

Today's Date: *12/30/2012* Birthdate: *3/2/1943* Age: *69*

Address *4506 45th WY* *Mangonia Park, FL, 33407*
*City* *State* *Zip*

Home phone number: *(333) 444-5555* Cell phone number: _____

E mail: *robert@gmail.com* Employer: _____ Occupation: _____

Spouse's Name: _____ Primary Care Physician: _____

How did you hear about Northgate Hearing? _____

**PERSON RESPONSIBLE FOR BILL** (if other than patient) _____

**PERSON TO CONTACT IN CASE OF EMERGENCY** (different from patient)

Name: _____ Relationship: _____ Phone Number: _____

Address: _____

**INSURANCE INFORMATION**

Insurance Company: *AARP UnitedHealthcare Insurance Co.*

We are not a Medicare or Medicaid provider. However, we are happy to bill any other insurance that covers hearing related services. Please present your insurance card(s) to the receptionist.

**NOTICE OF PRIVACY PRACTICES**

I acknowledge the receipt of Northgate Hearing Services, Inc. "Notice of Privacy Practices" brochure and have read and understand this notice.

_____ _____
Signature Date

**NOTICE OF INFORMED CONSENT**

I understand that some recommended procedures carry a small amount of risk. These include complications that may occur during the taking of ear impressions or the removal of earwax from the ear canal. I have read the above and understand it.

_____ _____
Signature Date