Northwest Florida ENT

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

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

Please Print Clearly, in blue or black INK

PATIENT INFORMATION

First Name Robert Middle Initial L. Last Name Smith
Address (Street) 4506 45th WY
City Mangonia Park ST: FL Zip: 33407
Home Phone: _____ Work Phone: : _____ Cell: : _____
Birth Date 3/2/1943 Age: 69 Male _____ Female _____
Social Security # 222-33-2234 Patient's Occupation: _____
Employer _____Is Patient a full-time student? Yes _____ No _____
Marital Status: Married____ Divorced___ Single____ Separated____ Widowed____
Spouse's Name _____ Parent's Name(s) (if pt. is under 18) _____
Referred by: Newspaper Half Page Ad
Primary Physician: _____ Phone #_____
ENT Physician: _____ Phone #_____
Emergency Contact: _____ Phone #_____
How did you hear about Family Audiology Associates, Inc.? (Please check one):
_____Referred by Physician _____Referred by Friend _____Radio Ad (name)
_____Newspaper Ad (name) _____School _____Yellow Pages _____Online _____Other

Insurance Information (Please submit Copies)

This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claims.

Primary Insurance: _____
Address: _____
Phone#: _____ Group ID#: _____Insurance ID#: _____
Primary Cardholder _____ Birthdate_____Relationship_____
Primary Cardholder's employer: _____ Social Security #: _____
Address of Cardholder if Different from Patient: _____

Secondary Insurance: _____
Address: _____
Phone #: _____ Group#: _____ ID# _____
Primaryardholder: _____Birthdate:_____ Relationship: _____
Primary Cardholder's employer:_____ Social Security #: _____
Address of Cardholder if Different from Patient: _____

SIGNATURE AUTHORIZATION

Family Audiology Associates, Inc. is a privately owned company and all scheduling and billing will be conducted through the corporation. I authorize direct payment of any medical benefits for services performed at Family Audiology Associates, Inc., be sent directly to the Celina office. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. Family Audiology will be happy to assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is also my responsibility to contact my insurance carrier to determine if Family Audiology Associates, Inc is in my specific network.

I authorize Family Audiology Associates, Inc. to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.

I understand that it is my responsibility to notify Family Audiology Associates, Inc. if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a "no show" fee for which I will assume responsibility. I also permit a copy of this authorization to be used in place of the original. I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Signature: _____Date: _____