Valley Audiology Client Information

Today's Date _____

Last Name _____ First Name _____ Initial _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Telephone Number _____ Cell Phone Number _____ Work Telephone Number _____

Employer/School _____ Occupation _____ Email Address _____

Physician Information

Primary Care Physician _____ City _____ Telephone Number _____

Referring Physician _____ City _____ Telephone Number _____

If Child:

Father's Last Name, First Name _____ Mother's Last Name, First Name _____

Referral

How did you hear about Valley Audiology? (circle below)

☐Physician ☐Friend ☐Relative ☐Insurance ☐Newspaper ☐Yellow Pages ☐Website ☐Other:_____

If someone referred you, please indicate name: _____

May we use your name in thanking the person who referred you? (circle one) ◯Yes ◯No

Are you interested in a financing plan available for Hearing Aids through Care Credit: ◯Yes ◯No

Insurance Information - ***Insurance Card Must be Present at Time of Appointment***

Insurance Carrier _____ Subscriber ID Number _____ Group Number _____

Policy Holder Last Name, First Name _____ Policy Holder Date of Birth _____ Relationship to Client _____

Policy Holder Employer _____ Policy Holder Social Security Number _____ Policy Co-Payment Amount _____

I authorize the release of medical information to process this claim. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Policy Holder Signature _____ Policy Holder Printed Name _____ Date _____