



## Patient Information

Today's Date \_\_\_\_\_

Last Name	First Name	Middle Initial	Date of Birth
Address	City	State	Zip
Home Telephone Number	Cell Telephone Number	Work Telephone Number	
Employer/School	Occupation	Email Address	

### Physician Information

Primary Care Physician	City	Telephone Number
Referring Physician	City	Telephone Number

### If Child

Parent/Guardian's Last Name, First Name	Parent/Guardian's Last Name, First Name
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### Referral

How did you hear about Acro Audiology? (check below)

Physician  Friend  Relative  Insurance  Newspaper  Website  Other \_\_\_\_\_

If someone referred you, please indicate name \_\_\_\_\_

May we use your name in thanking the person who referred you?  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 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
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