ACROAUDIOLOGY
HEARING CARE CENTER

Patient Information

Today's Date _____

Last Name	First Name	Middle Initial	Date of Birth

Address	City	State	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

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

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