# Patient Information Form

Last Name _____ First Name _____ MI_____

Birth Date _____ Sex_____ Home Phone #_____ Other #_____

Social Security # _____

Mailing Address (Street) _____

City_____ State_____ Zip code_____

Whom may we contact in case of an emergency?_____ Phone #_____

Whom may we thank for referring you to our office?_____

Primary Care Physician _____ Phone#_____

Primary Ins._____ Ins. ID#_____ Group#_____

Name of Policyholder_____ Policyholder's Birth Date _____

Secondary Ins._____ Ins. ID#_____ Group#_____

Name of Policyholder_____ Policyholder's Birth Date _____

I authorize to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify of any changes in my health status or in the above information.

I acknowledge I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

Signature_____ Date_____

Parent Signature if Minor_____ Date_____

Hearing Health Center

**517.364.5678**
1200 E Michigan Ave, Ste 330
Lansing, MI 48912

**517.889.1921**
800 E Columbia St
Mason, MI 48854

**989.224.1575**
1079 S Old US-27
St. Johns, MI 48879