5333 North Dixie Highway, Suite 105
Fort Lauderdale, Florida 33334
(954) 491-3707 • Fax (954) 491-1201
northeasthearing@bellsouth.net

PATIENT INFORMATION

NAME: ______________________________ DOB: __________ AGE: _____________ SEX: ________

ADDRESS: ___________________________________ APT# ________ CITY: ______________________

STATE: _____ ZIP: __________ HOME: (____) ________________ CELL: (____) _______________

FULL TIME RESIDENT: Y / N ALTERNATE ADDRESS: _______________________________________

EMAIL ADDRESS: ____________________________ REFERRED BY: _____________________________

SPOUSES NAME: _______________________________________ PHONE NUMBER: ________________

IN EMERGENCY NOTIFY: _______________________________ PHONE NUMBER: ________________

PERSONAL PHYSICIAN: _________________________________ PHONE NUMBER: _______________

MEDICARE # ____________________________ OTHER INSURANCE: _____________________________

REASON FOR VISIT TODAY: ____

CURRENT MEDICATIONS: ____

METHOD OF PAYMENT CASH / CHECK / VISA / MC / AMEX / CARE CREDIT FINANCE PLAN

I UNDERSTAND THAT I MAY BE RESPONSIBLE FOR: MY DEDUCTIBLE, AND COPAYS, AND/OR SERVICES THAT MAY NOT BE COVERED BY MY INSURANCE PLAN.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO MY PERSONAL PHYSICIAN AND TO THE INSURANCE COMPANY IF NEEDED TO PROCESS MY CLAIMS.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

AUTHORIZED SIGNATURE ____