SOUTHSIDE HEARING CENTER

New Patient Intake Form

PATIENT INFORMATION				
DR. MR. MRS. MS. MISS *(circle one)*	PATIENT NAME		DATE OF BIRTH	GENDER
MARITAL STATUS	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE	E-MAIL ADDRESS
ADDRESS	CITY		STATE	ZIP
EMPLOYER	WORK PHONE NUMBER	OCCUPATION (OR FORMER OCCUPATION, IF RETIRED)		
WHO MAY WE CONTACT IN CASE OF EMERGENCY?	RELATIONSHIP TO PATIENT		HOME PHONE NUMBER	OTHER PHONE NUMBER
PRIMARY CARE PHYSICIAN	HOW WERE YOU REFERRED TO US?			

IF PATIENT IS A MINOR, PLEASE COMPLETE THIS SECTION				
FATHER OR GUARDIAN'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME/CELL PHONE	WORK PHONE
MOTHER OR GUARDIAN'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME/CELL PHONE	WORK PHONE

INSURANCE INFORMATION		
PRIMARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER (IF APPLICABLE)
SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER
SECONDARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER (IF APPLICABLE)
SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	PATIENT'S RELATIONSHIP TO SUBSCRIBER

AUTHORIZATION FOR TREATMENT: I authorize Southside Hearing Center to perform testing, care and management services relating to my hearing care needs.

PATIENT RESPONSIBILITIES: I understand that as the patient, parent or guardian, I am legally responsible for payment of all charges relating to my care. The patient and/or responsible party agrees to pay reasonable attorney fees and cost of collection if patient's account is placed in the hands of an attorney or collection agency for handling.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act, or under other insurance coverage is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers and/or State in which I reside or its Fiscal Agents, or the insurance company or its representatives any information needed for this or a related Medicare or other insurance claim. In consideration of services rendered, I transfer and assign to Southside Hearing Center any payment which may become due to me for medical services under policies applicable to me or my dependent.

USE OF PROTECTED HEALTH INFORMATION: I authorize Southside Hearing Center to use and release my protected health information for marketing related to hearing care products or services. I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.

Patient Signature (or parent/guardian if patient is a minor) _____ Date _____

SOUTHSIDE HEARING CENTER IS NOT A MEDICAID PROVIDER.