# Patient Information Form

www.HartHearing.com

Office Location (circle one): Irondequoit • Brighton • Brockport • Fairport • Greece • Watertown

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Last name: ______________________________ First name: ______________________________ MI: _____

Birthdate: _______________ Sex: _____ Home phone: ___________________ Cell: ___________________

Work: ___________________ SSN: __________________ SSN or guardian (if minor): _________________

Mailing Address (Street): ____________________________________________________________________

City: ____________________________________________ State: _______ Zip code: __________________

Employed by: _________________________________________________ Full time: _____ Part time: _____

Primary care or referring physician: _____________________________ Phone: ________________________

Emergency contact? _________________________________________ Phone: ________________________

Primary insurance company: ___________________________________________________________________

Insurance ID#: ______________________________________

Name of policy holder: ________________________________ Policyholder birthdate: __________________

Who is financially responsible for this visit? ____________________________ Phone: __________________

I authorize Hart Hearing Centers to release medical information necessary to process a claim for services. I hereby authorize payment directly to Hart Hearing Centers for services rendered.

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 hereby agree to pay Hart Hearing Centers for all reasonable charges. In the event that I fail to pay charges when due and Hart Hearing Centers refers the amount to an attorney for collection, I agree to pay the cost of the collection including attorney's fees.

Signature: ______________________________________________ Date: __________________________

Parent signature of minor: __________________________________ Date: __________________________