Welcome to our Clinic! We look forward to serving you with your hearing and speech needs. Complete these forms as fully as you can, even if you are unsure of the answers. If you have any questions with this paperwork, please feel free to ask the Office Manager at the front desk.

Date:_____

PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____

Street Address:_____

City, State, Zip Code: _____ Social Security: _____

Home Phone: _____ Cell: _____ Work Phone: _____

E-Mail Address:_____ Sex: Male Female

Patient's Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Employer's Name or School Name:_____

Relationship to Insured: □ Self □ Spouse □ Child □ Other:_____

HEALTH INSURANCE: INFORMATION (Primary)

Health Insurance Name:_____ ID# _____ Group #: _____

Name of Insured: _____ Date of Birth: _____ Social Security #: _____

Insured's Relationship to Patient: □ Self □ Spouse □ Child □ Other:_____

HEALTH INSURANCE INFORMATION (Secondary)

Health Insurance Name: _____ ID#_____ Group # _____

Name of Insured: _____ Date of Birth: _____ Social Security #: _____

Insured's Relationship to Patient: □ Self □ Spouse □ Child □ Other: _____

FINANCIAL RESPONSIBILITY (Person Responsible for the Patient Name Above) I understand that The West Tennessee Hearing & Speech Center may not participate with my insurance company. For participating insurance plans, I authorize the release of any information necessary to process medical claims for the patient named above and authorize that payment of benefits for these claims be made to this office. Also, I agree promptly pay for any services not covered by my insurance and or determined to be my responsibility (i.c., Deductibles, Co-payments such as 20% of the allowable fee for Medical Services when deemed "Reasonable and Necessary"). Insurance does not cover the cost of hearing aids. Payment is due at the time services are rendered. I agree to these payment terms and guarantee payment to The West Tennessee Hearing & Speech Center, for any services provided to the patient named above.

_____ _____ _____

Signature of Guarantor Date Social Security #

Relationship to Patient: □ Self □ Spouse □ Child □ Other:_____

PRIMARY CARE PHYSICIAN:_____

How did you hear about us? □ Doctor □ Radio □ Newspaper □ Friend □ Other:_____

Name: _____Address: _____