2940 Squalicum Pkwy, Suite 205
Bellingham, WA 98225
(360) 671-7530

PATIENT INFORMATION FORM

Last Name:_____ First Name:_____ MI:_____

Mailing Address (Street):_____ Apt/Space #:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ Date of Birth:_____

Social Security #:_____ Social Security # of Parent/Guardian (if minor) _____

Employer:_____ Occupation:_____

Primary Care Physician:_____ Phone:_____

Nearest relative not living with you:_____ Phone:_____

Whom may we contact in case of an emergency?_____Phone:_____

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

Primary Insurance Company:_____ Insurance ID#:_____

Name of Policy Holder:_____Policy Holder's Date of Birth:_____

Secondary Insurance Company:_____ Insurance ID#:_____

Who is financially responsible for this visit?_____ Phone:_____

I will pay today by: Cash_____ Check_____ Credit Card_____ Other (please state) _____

I authorize Hearing Health Clinic 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 Hearing Health Clinic of any changes in my health status or in the above information.

Signature:_____ Date:_____

Parent/Guardian Signature if Minor:_____ Date:_____