Aurora Audiology & Speech Associates, Inc. Patient Information

Welcome To Our Office

Circle one Mr.
Ms.
Mrs.
Child

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Email: _____ Social Security # _____

Primary Care Physician & ***Address*****:** _____

Referring Physician (if applicable, i.e.: ENT) _____

Others Needing Report & ***Address*****:** _____

_____

If dependent:

Parent/legal guardian name: _____

Home Phone _____ Work Phone _____

IN ORDER TO ENSURE THE FULL UTILIZATION OF YOUR BENEFITS, PLEASE COMPLETE THE FOLLOWING:

Policy Holder's Employer/Retired from _____

Primary Insurance Company Name _____

Policy Holder's Name _____ DOB _____ Relationship to Patient _____

Secondary Insurance Company Name _____

Policy Holder's Name _____ DOB _____ Relationship to Patient _____

How did you hear about our office? ___Physician ___yellow pages ___other: _____
___newspaper ___friend/relative-Who? _____

ASSIGNMENT OF BENEFITS
(Authorization to pay and release information)

I hereby authorize all benefits to be paid to Aurora Audiology & Speech Associates, Inc. for charges for examination and/or treatment received by my dependents or me. I hereby authorize benefit payers to release any and all information requested regarding such benefit payments to Aurora Audiology & Speech Associates, Inc. **Any balance not covered by insurance or applied to my deductible is payable directly by me.**

I authorize the release of any medical information necessary to process any claim for examination and/or treatment received by my dependents or me. I also grant permission to release my or my dependent's records to our physicians and those stated above.

_____ _____

Signature of Patient or Legal Guardian Date