PATIENT INFORMATION SHEET ☐ BROOKLYN ☐ MANHATTAN

TODAY'S DATE _____

PATIENT NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME TELEPHONE_____ WORK TELEPHONE_____

CELL PHONE_____ MALE____ FEMALE ____

DATE OF BIRTH _____ REFERRING DR._____

INSURANCE INFORMATION:

WHAT IS YOUR PRIMARY INSURANCE COMPANY?_____

NAME OF INSURED _____INS.#_____

DATE OF BIRTH OF INSURED_____RELATION TO PATIENT_____

WHAT IS YOUR SECONDARY INSURANCE COMPANY?_____

NAME OF INSURED_____INS #_____

I understand that all medical costs incurred by me are my responsibility, including deductible, co-insurance,co-payments and any charges my insurance fails to pay. I also understand that I am responsible for any collection and/or legal efforts that may be necessary on my account. I authorize payment of medical benefits to Dassan Ali, Sc.D., CCC-A/Audiological Diagnostics, P.C. for services provided. I authorize the release of any medical or other information necessary to process this claim.

I have received this practice's Notice Of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

*SIGNATURE OF PATIENT*_____*DATE*_____

HEARING AID INFORMATION:

DATE: _____ *TYPE/MODEL:*_____

RIGHT SERIAL #_____LEFT SERIAL #_____

BATTERY SIZE:_____WARRANT EXPIRES:_____