PATIENT INFORMATION

Thank you for choosing Innsbruck Hearing & Balance Center for your audiology care. In order to help us complete your records and submit accurate bills to your insurance company, please provide the following information.

Today's Date: _____ Patient's Soc. Sec. #: _____

First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: ___ ___ _____ Work Phone: ___ ___ _____

Mobile Phone: ___ ___ _____ E-mail Address: _____

Employer: _____ Occupation: _____

Referred By: ☐ Self ☐ Friend ☐ Insurance Carrier ☐ Primary Physician ☐ Specialty Physician
☐ Audiologist ☐ Physical Therapist ☐ Other _____

Primary Care Physician & Office: _____

Referring Physician & Office (if different): _____

Insurance Patients

Please complete the following section and present your Insurance Cards

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured:	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other
Complete the following insured information if *RELATION* is other than *SELF*		
Insured's Name:		
Insured's Birthdate:		
Insured's Soc. Sec. #:		
Male or Female:		
Employer:		
Complete the following insured information if it differs from the Patient's		
Insured's Address:		
City, State, ZIP:		
Phone Number:		

ACCIDENT PATIENTS

CLAIM FILING INFORMATION	
WORKER'S COMPENSATION OR MEDPAY INFORMATION	ATTORNEY INFORMATION
Date of Injury:	☐ Attorney only - no WC or Medpay info
Insurance Carrier Name:	Name:
Carrier Address:	Address:
City, State, ZIP:	City, State, ZIP:
Adjuster's Name:	Contact:
Adjuster's Phone:	Phone:
Claim Number:	File No:

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician or audiologist to diagnose and treat my condition(s). Further, I authorize assignment of my insurance rights and benefits directly to the provider and also authorize the release of such information as is needed to process insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees, or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this

_____ I have read and understand the Notice of Information Disclosure for Innsbruck Hearing & Balance Center
(Please Initial)

Patient Signature: _____ Date: _____