# American Hearing Center

1618 Canyon Creek Dr.
Suite 140
Temple, TX 76502
254-774-7727

## Patient Information

**Patient's Name** ____________________________________________
First Initial Last

**Responsible Party (if patient is a child, Parent or Guardian)** ____________________

**Address** ____________________________________________

**City** ____________________ **State** __________ **Zip Code** __________

**Home Phone** __________ **Work** __________ **Mobile** __________ **Other** __________ **Primary:** ☐ H ☐ W ☐ M ☐ O

**Social Security #** __________ **Date of Birth** __________ **Sex** M F (circle) **Email** ____________________

**Marital Status** Married Single Other (circle) **Employment Status** FullTime PartTime None (circle) **Student Status** FullTime PartTime None (circle)

**Referring Physician** ____________________ **Primary Physician** ____________________

**Is there a place/physician we can send a copy of your test results?** ____________________

**Emergency Contact** ____________________ **How did you hear about us?** ____________________

**How would you like to receive Appointment Notifications?** ☐ Telephone ☐ Text ☐ Email ☐ None

## Primary Insurance Information

***(if patient is also the insured, enter 'SAME' for name & address)*** *(Office only): Insurance Card copy on file?* ______

**Insured's Name** ____________________________________________
First Initial Last

**Address** ____________________________________________

**City** ____________________ **State** __________ **Zip Code** __________

**Home Phone** ____________________ **Work Phone** ____________________

**Patient Relation to Insured** Self Spouse Child Other (circle) **Insured Date of Birth** __________ **Insured Sex** M F (circle)

**Insured Employment Status** FullTime PartTime None (circle) **Insured Employer** ____________________

**Insurance Co. Name** ____________________ **Subscriber ID Num** __________ **Group Num** __________

## Other Insurance Information

***(if patient is also the insured, enter 'SAME' for name & address)*** *(Office only): Insurance Card copy on file?* ______

**Insured's Name** ____________________________________________
First Initial Last

**Address** ____________________________________________

**City** ____________________ **State** __________ **Zip Code** __________

**Home Phone** ____________________ **Work Phone** ____________________

**Patient Relation to Insured** Self Spouse Child Other (circle) **Insured Date of Birth** __________ **Insured Sex** M F (circle)

**Insured Employment Status** FullTime PartTime None (circle) **Insured Employer** ____________________

**Insurance Co. Name** ____________________ **Subscriber ID Num** __________ **Group Num** __________

**I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.**

**Signed** ____________________________________________ **Date** ____________________