



Patient Information

Name: _____ Date of Birth: _____
 Gender: Male Female Other Pronouns: _____
 Address: _____ Apt#: _____
 City: _____ State: _____ Zip: _____
 Primary Phone: _____ (cell / work / home) Cell Phone Carrier: _____
 Secondary Phone: _____ (cell / work / home)
 Employer: _____ Occupation: _____
 Work Address: _____
 Social Security #: _____ Email Address: _____
 Primary Care Physician _____ Phone Number: _____
 Marital Status: Single Married Divorced Separated Widowed Partnered

Spouse Partner Parent Guardian Information (Check One)

Name of spouse, parent or guardian: _____
 Street Address: _____ Apt #: _____ City: _____ State: _____ ZIP: _____
 Mailing Address (if different): _____
 Home Phone: _____ Work Phone: _____
 Employer: _____ Occupation: _____
 Work Address: _____
 City/State/Zip _____ Date of Birth: _____
 Social Security #: _____ Driver's License #: _____

Insurance Holders' Information

Primary Insurance Co: _____ Phone #: _____
 Name of Insured: _____ Date of Birth: _____
 Home Phone: _____ Work Phone: _____
 SS or ID #: _____ Group #: _____ Co-Pay Amount \$ _____

Primary Insurance Co: _____ Phone #: _____
 Name of Insured: _____ Date of Birth: _____
 Home Address: _____ Home Phone: _____
 SS or ID #: _____ Group #: _____

PLEASE PROVIDE YOUR INSURANCE CARD TO PHOTOCOPY

Other Important Information

Person to contact in an emergency (someone not living with you): _____
 Relationship to you: _____ Their phone #: _____
 How did you hear about our doctors? Phone Book Referred by Friend or Family Member
 Referred by Physician: _____ Previous Patient: _____
 Other (please specify): _____

I authorize Pacific Audiology Clinic or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by Pacific Audiology Clinic, LLC and that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and acknowledges that their social security number may be used in collection efforts. I authorize Pacific Audiology Clinic to provide me with reasonable and proper medical care by today's standards.

Signature _____ Date _____