Ear Labs Hearing Consultants

1132 San Marino Drive, Suite 104
Lake San Marcos, CA 92078
(760)744-1551; Fax (760) 591-9665

PATIENT IDENTIFICATION

SEX: ☐ M ☐ F

LAST NAME | FIRST NAME | MIDDLE

STREET ADDRESS / MAILING ADDRESS / DOB / AGE

CITY | STATE | ZIP CODE | SOCIAL SECURITY NUMBER

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW

HOME PHONE | BUSINESS PHONE | CELL PHONE

EMPLOYER | OCCUPATION | REFERRED BY | PHONE NUMBER

SPOUSE'S NAME | SPOUSE'S DOB | SPOUSE'S SSN | EMPLOYER

EMERGENCY CONTACT (NAME) / RELATIONSHIP | ADDRESS / PHONE NUMBER

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

NAME OF PRIMARY INSURANCE | INSURANCE ADDRESS | INSURANCE PHONE #

INSURED'S NAME | DOB | SSN | POLICY # | GROUP #

FINANCIAL RESPONSIBILITY

LAST NAME | FIRST | SSN | RELATIONSHIP TO PATIENT

STREET ADDRESS | CITY | STATE | ZIP | PHONE NUMBER

EMPLOYER NAME | EMPLOYER ADDRESS | BUSINESS/CELL PHONE

- I consent to treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I acknowledge full financial responsibility for services rendered by the audiologist if my insurance denies or reduces payment.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I further authorize and request that insurance payments be made directly to: Ear Labs Hearing Consultants.
- I am also aware that there is a $30.00 fee for returned checks. Should my account be turned over to a collection agency, I am responsible for the 30% added to the collection fees, plus any legal fees.

Signature: ______________________ Date: ____________