Audiology and Hearing Aid Center of Gainesville

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www.audiologyandhearingaid.com
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Patient Information

Patient Name:_____

Preferred Name:_____

Date of Birth:_____ Age:_____

Address: _____
Street

_____
City *State* *Zip Code*

Parent/Caregiver Name:_____
(if applicable)

Phone: Home_____ Cell_____ Work_____

Emergency Contact:_____
Name *Phone* *Relationship to Patient*

Email Address:_____

Referred By:_____

Primary Care Physician:_____

In order to keep overhead costs to a minimum, co-pays and payments for services not covered by health insurance are expected at time of appointment. I understand that I am responsible for obtaining appropriate referrals required by my health insurance policy. I understand that I will be financially responsible for any portion of payment not covered by health insurance.

_____ _____
Signature of person responsible for payment Date