BIGHORN HEARING CENTER INC.

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different):

_____

SS# _____ Date of Birth: _____ Male: _____ Female: _____

Occupation: _____ Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

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Responsible Party Information (for patients or minors insured under family member insurance)

Responsible Party/Parent Name: _____ Relationship to Patient: _____

Date of Birth: _____ Occupation: _____

Phone Number: _____

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Insurance Information

Company Name: _____ Policy Number: _____

Member I.D.: _____

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I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and or surgical benefits, including major medical benefits to which I am entitled to Bighorn Hearing Aid Center. A photocopy of this release is to be considered as valid as the original.
I AGREE TO BE FINACIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

Patient or Guardian Signature: _____ Date: _____