

# **CAROLINA HEARING SERVICES, INC.**

For your convenience, we are updating our computer system.  
**PRINT CLEARLY** when completing the following information.

Patient Name \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Patient Address \_\_\_\_\_  
City State Zip

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_ Employment: Full time \_\_\_ Part-time \_\_\_ None \_\_\_

Student: Fulltime \_\_\_ Part-time \_\_\_ None \_\_\_ Referring Physician \_\_\_\_\_

How were you referred to us? \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

## **PRIMARY** INSURANCE COMPANY \_\_\_\_\_

Insured's ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Name \_\_\_\_\_ Address \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Patient relationship to insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

Insured's Employment Status: Fulltime \_\_\_ Part-time \_\_\_ None \_\_\_

Insured's Employer \_\_\_\_\_

## **SECONDARY** INSURANCE COMPANY \_\_\_\_\_

Insured's ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Name \_\_\_\_\_ Address \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Patient relationship to insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

Insured's Employment State: Fulltime \_\_\_ Part-time \_\_\_ None \_\_\_

Insured's Employer \_\_\_\_\_

## **PLEASE BE SURE TO SIGN AND DATE**

I have completed this form to the best of my knowledge and give my consent to be seen and treated at Carolina Hearing Services, Inc. I accept total responsibility for all charges. I give my permission for Carolina Hearing Services, Inc. to release information to my insurance carrier at their request.

I authorize this form to be used as my Signature on File.

Signed \_\_\_\_\_ Date \_\_\_\_\_