

### Patient Information Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_  
Street Apt# City State Zip

Primary Phone #: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Other Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
Name Phone Number Relationship

**SPOUSE INFORMATION REQUIRED IF YOUR SPOUSE IS THE PRIMARY POLICY HOLDER OF YOUR INSURANCE**

Spouse Name: \_\_\_\_\_ Daytime Phone# \_\_\_\_\_  
 Spouse Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Spouse Social Security #: \_\_\_\_\_

**PLEASE COMPLETE THIS SECTION IF A PATIENT IS A MINOR ( under 18 years of age)**

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

**WHO REFERRED YOU TO THIS OFFICE?**

Physician: \_\_\_\_\_ Internet Newspaper/Magazine  
 Friend/Family: \_\_\_\_\_ Yellow Pages Insurance  
 Other: \_\_\_\_\_ Mailing Radio

**RELEASE OF MEDICAL INFORMATION**

Primary care physician \_\_\_\_\_  
Name City Phone

I, \_\_\_\_\_, hereby authorize Kaw Valley Hearing to release any and all medical information in the course of my (or my child's) treatment to the physician(s), person or organization listed above.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**NOTICE OF RESPONSIBILITY**

I understand that if I do not have insurance or my insurance is not accepted by Kaw Valley Hearing, I need to make payment, *in full*, at time of service. Kaw Valley Hearing will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

Kaw Valley Hearing accepts payment by Cash, Personal Check, Money Order/ Cashier's Checks, MasterCard, Visa, Discover, American Express and KATCO Financing Option. If other arrangements are necessary, I will discuss them with the office staff before I am examined by the audiologist. A returned check fee of \$30.00 will be applied to the patient's account which issued the check.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**IN ORDER FOR US TO FILE YOUR INSURANCE CLAIM FOR YOU, THE FOLLOWING MUST BE SIGNED:**

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits, to be made directly to Kaw Valley Hearing for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date