



Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone: _____ Cell: _____

Work Phone: _____ Social Security # _____

Mailing Address (Street) _____

City _____ ST _____ ZIP _____

Email Address: _____

Family Member: _____ Work Phone # _____

Nearest Relative not living with you _____ Phone # _____

Whom may we contact in case of an emergency? _____ Phone # _____

Whom may we thank for referring you to our office? _____

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth _____

Secondary Ins. _____ Insurance ID# _____

Who is financially responsible for this visit? _____ Phone # _____

I will pay today by Cash _____ Check _____ Credit Card _____ Other # _____

I authorize Moore Hearing Centers to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Moore Hearing Centers of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____