VICTORY
HEARING & BALANCE

PATIENT INFORMATION

Name:_____

DOB: ____/____/_____ SSN: _____-_____-_____

Address:_____

City:_____ State:_____ Zip code: _____

Home Phone:(____)_____

Cell Phone:(____)_____

Work Phone: (____)_____ Occupation: _____

E-Mail : _____

Preferred method of contact? _____

Marital Status: _____

Emergency Contact: _____ Phone: (____)_____

Primary Care Provider :_____

How did you hear about us?_____

I assign directly to Victory Hearing and Balance/Victory Medical and Family Care all healthcare benefits otherwise payable to me for services rendered. I further authorize and direct all responsible insurance companies to make checks payable to Victory Hearing and Balance/Victory Family and Medical Care. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment from my health insurance carrier. Furthermore, I do hereby grant to any officer or designated employee of Victory Hearing and Balance/Victory Medical and Family Care the right to endorse for me and in my name, place, and stead all checks relating to the services provided to me by Victory Hearing and Balance/Victory Medical and Family Care. I have been presented with a copy of Victory Hearing and Balance/Victory Medical and Family Care's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law.

X_____ _____

Signature Date