DIVERSIFIED
Hearing & Balance Centers

Date: ___/____/_____

PLEASE PRINT CLEARLY

Name: _____ Birth date: _____Age: _____

Primary Address:_____
Street City State Zip

Secondary Address:_____
Street City State Zip

Home Phone: (_____) _____ Cell Phone: (_____) _____

Other Phone: (_____) _____ Social Security #: _____

Email Address:_____
For periodic emails, i.e. newsletter, product updates, etc. We will not share your information.

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Spouse's Name:_____ Parent/Guardian's Name: _____

Employer: _____ Occupation: _____

Primary Care Physician:_____ Phone: (_____)_____

Emergency Contact: _____ Phone: (_____)_____

Relationship to patient:_____

Who may we thank for your referral? (Please check all that apply)

☐ Physician name: _____ ☐ Hearing Care Specialist's Website _____

☐ Friend name: _____ ☐ Online Search

☐ Newspaper Ad/Insert name: _____ ☐ Other _____

☐ Yellow Pages: ❍Verizon ❍Talking ☐ TV Commercial, channel: _____

Insurance Information (Please present your insurance card/s)

Primary Insurance: _____ ID#:_____ Group #: _____

Policy Holder: _____ Relationship to Insured:_____

Secondary Insurance: _____ ID#:_____ Group #: _____

Policy Holder: _____ Relationship to Insured:_____

Worker's Compensation Information

Insurance Carrier: _____ ID#:_____ Case #:_____

Consent to Treat/Release/Acknowledgements and Assignment:

By signing below, I authorize Diversified Services to examine and/or treat me. By signing below, I also authorized the release of any information to all doctors and contacts listed above and additionally, authorize the release of any/all records that may be pertinent to my care. I have also reviewed all of the above information and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. If at anytime, my account becomes delinquent and is referred to collection, I will be responsible for any interest, penalties and attorney's fees that may be incurred. I understand that my insurance company may pay less than the actual bill for services and/or products. I agree to be responsible for any unpaid balance. I further acknowledge that I have received a copy of Notice of Privacy Practices and I am in agreement that I may receive periodic literature or promotions by mail, email and also agree that messages may be left at the given phone numbers that may involve information regarding my status as a patient.

Signature: _____ Date: _____