



BRIDGE
HEARING
CENTER

Understanding matters. Bridge the gap.

Patient Information Form

Patient Name:
First M Last DOB (MM/DD/YY)

Mailing Address:

Home Phone #: Cell Phone #:
City

Preferred Method of Contacting: Home Cell Texting Email

Email Address Last 4 SSN Sex: M / F
↓ VA ONLY ↓

Retired: Yes No Occupation:
If retired, prior occupation

Spouse/ Partner Name:

Emergency Contact: Phone #

Relation to Patient:

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records. **If the insurance is NOT under your name, please complete this section.**

Name of Subscriber: _____
First MI Last

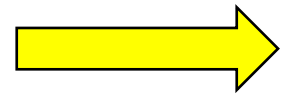
DOB: _____ Relationship: _____
MM/DD/YY

Primary Care Physician: Phone #:
First Last

Referring Physician: Phone #:
First Last

How did you hear about us? Mail Billboard Drive By
 Other Physician Referral Commercial

Referred by Friend: _____
First Last





B R I D G E
H E A R I N G
C E N T E R

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Please read carefully and sign below

- I hereby authorize the release of any information necessary to provide audiological or medical history to Bridge Hearing Center.
- I also authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to Bridge Hearing Center.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy at this office.
- I understand and agree to be personally responsible for the balance and/or deductibles as stipulated by my policy.
- I certify this information is true and correct to the best of my knowledge. I have read all the information on this sheet and have completed the above questions.
- I hereby give Bridge Hearing Center permission to treat my concerns.

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original)

Date