

# Audioscope Audiology Group, APC

3702 Ruffin Road, Suite 100, San Diego, CA 92123

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Init. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone # (\_\_\_\_) \_\_\_\_\_

Physician's Address \_\_\_\_\_

How did you hear about us? Dr.'s Office \_\_\_\_ Yellow Pages \_\_\_\_ Website \_\_\_\_ Friend \_\_\_\_ Other \_\_\_\_\_

Is condition work or accident related? \_\_\_\_\_ If YES, explain \_\_\_\_\_

## RESPONSIBLE PARTY

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Member # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Member # \_\_\_\_\_

## RELEASE OF INFORMATION AND BILLING ASSIGNMENT

I authorize release of medical information related to my treatment and/or examination at Audioscope to referring providers, business associates and insurance carriers to process claims.

\_\_\_\_\_  
Patient's or Authorized Person's Signature

\_\_\_\_\_  
Date

I authorize payment of medical benefits to Audioscope. I understand that I am responsible for all charges not paid by my insurance.

\_\_\_\_\_  
Patient's or Authorized Person's Signature

\_\_\_\_\_  
Date