Date:____________________

Full Name:________________________________ Gender: M F

Social Sec #:__________________ Date of birth:__________________

Address:____

____

Parent(s)/guardian (if minor)__________________________________

Relationship to patient:_____________________

Telephone numbers: Home:_____________Work:__________________

Cell:______________________ Email:___________________________

Insurance Carrier#1:____________________ Policy #______________

#2:____________________ Policy #______________

#3:____________________ Policy #______________

Insured:__________________ Emergency contact:________________

Primary Care Physician (PCP):________________________________

Who referred you here, or how did you hear of Sumter Hearing Associates?

____

Who will be responsible for payment:___________________________

Signature (on file):____

Payment is expected at the time of service, to include insurance deductibles and/or co-payments unless prior arrangements have been made.