Lansdowne Hearing

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**Please complete the information below and sign.**

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ Zip: _____

Home phone number: _____ Cell phone number: _____

Email: _____ Spouse's Name: _____

Primary Care Physician: _____ Referring Physician _____

How did you hear about Lansdowne Hearing? _____

**PERSON RESPONSIBLE FOR BILL** (if other than patient) _____

**PERSON TO CONTACT IN CASE OF EMERGENCY** (different from patient)

Name: _____ Relationship _____ Phone: _____

Address: _____

**INSURANCE INFORMATION**

Insurance Company: _____

**Please present your insurance card(s) and a photo ID to the front desk.**

I assign all medical benefits to which I am entitled, under private insurance, or any other health plan. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, copayments and annual deductibles.

_____ _____

**Signature** **Date**