

# VALLEY Hearing Consultants

1073 Ross Avenue, Suite F  
El Centro, CA 92243  
(760)353-2525; Fax (760) 353-5996

## PATIENT IDENTIFICATION

SEX:  M  F

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE

\_\_\_\_\_  
STREET ADDRESS MAILING ADDRESS DOB AGE

\_\_\_\_\_  
CITY STATE ZIP CODE SOCIAL SECURITY NUMBER  
 SINGLE  MARRIED  
MARITAL STATUS  DIVORCED  WIDOW

\_\_\_\_\_  
HOME PHONE BUSINESS PHONE CELL PHONE

\_\_\_\_\_  
EMPLOYER OCCUPATION REFERRED BY PHONE NUMBER

\_\_\_\_\_  
SPOUSE'S NAME SPOUSE'S DOB SPOUSE'S SSN EMPLOYER

\_\_\_\_\_  
EMERGENCY CONTACT (NAME) RELATIONSHIP ADDRESS PHONE NUMBER

## INSURANCE INFORMATION

**PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST**

\_\_\_\_\_  
NAME OF PRIMARY INSURANCE INSURANCE ADDRESS INSURANCE PHONE #

\_\_\_\_\_  
INSURED'S NAME DOB SSN POLICY # GROUP #

## FINANCIAL RESPONSIBILITY

\_\_\_\_\_  
LAST NAME FIRST SSN RELATIONSHIP TO PATIENT

\_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP PHONE NUMBER

\_\_\_\_\_  
EMPLOYER NAME EMPLOYER ADDRESS BUSINESS/CELL PHONE

- I consent to treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
- I acknowledge full financial responsibility for services rendered by the audiologist if my insurance denies or reduces payment.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I further authorize and request that insurance payments be made directly to: Ear Labs Hearing Consultants.
- I am also aware that there is a \$30.00 fee for returned checks. Should my account be turned over to a collection agency, I am responsible for the 30% added to the collection fees, plus any legal fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_