111 Fieldstone Drive, Ste. 106 Milledgeville, GA 31061
(478) 452-0578 Fax (478) 453-0967
1713 Mount Vernon Road, Ste. 3 Dunwoody, GA 30338
(770) 394-9499 Fax (770) 394-9469
1051 Parkside Commons, Ste.103 Greensboro, GA 30642
(706) 454-0578 Fax (706) 454-0575
1991 N. Williamsburg Drive, Ste. A Decatur, GA 30033
(404) 500-1026 Fax (404) 883-2473

Adult Patient Information

Patient Name: Last _____First_____ MI ____

Nickname: _____

S.S. #: _____ Date of Birth: _____

Male ___ Female ___ Marital Status: S M D W (circle one)

Address: _____ Spouse: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer and/or Retired: _____

Work Phone: _____ E-mail address: _____

****Responsible Party – Full Name: _____**
Relationship to Patient: _____
Birth date: _____ (must have for primary holder)
Address: _____
Phone: _____ cell/ home/ work

Primary Physician: _____ Phone #_____

****____ (Initial) I hereby, grant permission to share information to my Primary Care Physician.**

How did you hear about us? _____

Primary Insurance _____Policy Holder _____

Secondary Insurance _____ Policy Holder _____

Emergency Contact Name: _____

Their relation to you: _____

Their phone: _____

Payment of all Co-pays, deductibles, and any other patient responsibility fees are due when services are rendered. Necessary forms will be completed to expedite insurance carrier payments. I hereby assign to Hearing Associates, all payments for services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

Signature: _____ Date: _____ ** - must be completed.