Advanced Audiology Of Greater Omaha – New Patient Information

Name: _____ Date of Birth: _____ Age: _____
Title First MI Last

Address: _____
Street Apt # City State Zip

Email Address: _____ (please check preferences below)

☐ I prefer email for appointment confirmations
☐ I do **not** wish to receive a quarterly emailed newsletter or special offers
(Advanced Audiology of Greater Omaha will not share your email address with a third party.)

Primary Phone #: _____ Secondary Phone #: _____
Work Phone #: _____Employer: _____

SPOUSE INFORMATION REQUIRED IF YOUR SPOUSE IS THE PRIMARY POLICY HOLDER OF YOUR INSURANCE

Spouse's Name: _____ Date of Birth: _____
Spouse's Employer: _____ Phone #: _____

IF PATIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

Mother's Name: _____ Work Phone: _____
Father's Name: _____ Work Phone: _____

Primary Insurance: _____
Secondary Insurance: _____

How did you hear about us? _____

Primary Care Physician: _____ Phone: _____

Other Physician, Person or Organization**:** _____

I, _____, authorize Advanced Audiology of Greater Omaha, LLC to release any and all medical information in the course of my treatment to the physician(s), person or organization listed above.

_____ _____/_____/_____
Signature of Patient, Parent or Guardian Date

ASSIGNMENT OF BENEFITS-RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to Advanced Audiology of Greater Omaha, LLC. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment.

_____ _____ / _____ / _____
Signature of Patient, Parent or Guardian **Date**

Guardian's Signature: _____ (If patient is under 18yrs)