

**Mid-America Audiology Group, Ltd.**

1417 Washington Avenue, Suite 2

Alton, IL 62002

(618) 462-9700

*PATIENT INFORMATION*

Date\_\_\_\_\_

Home Phone(\_\_\_\_)\_\_\_\_\_

Cell Phone(\_\_\_\_)\_\_\_\_\_

Name\_\_\_\_\_

Social Security #\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_

Gender: \_\_M/F\_\_ Age:\_\_\_\_\_ DOB:\_\_\_\_\_

Single          Married          Widowed

Minor          Separated          Divorced

Patient Employer\_\_\_\_\_

Work Phone(\_\_\_\_)\_\_\_\_\_

Spouse/Parent\_\_\_\_\_

Spouse/Parent Phone(\_\_\_\_)\_\_\_\_\_

Primary Care Physician/Referring Physician\_\_\_\_\_

Phone(\_\_\_\_)\_\_\_\_\_

*PRIMARY INSURANCE*

Person Responsible for Account\_\_\_\_\_

Relationship to Patient\_\_\_\_\_

DOB\_\_\_\_\_

Social Security #\_\_\_\_\_

Phone Number( )\_\_\_\_\_
Address (if different from Patient)\_\_\_\_\_
City\_\_\_\_\_ State \_\_\_\_
Responsible Party's Employer\_\_\_\_\_
Occupation\_\_\_\_\_
Insurance
Company\_\_\_\_\_
Contact #\_\_\_\_\_
Group #\_\_\_\_\_ Subscriber #\_\_\_\_\_

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? \_\_\_Y/N\_\_\_
If yes, Insurance
Company\_\_\_\_\_
Subscriber's Name\_\_\_\_\_
DOB\_\_\_\_\_ Social Security #\_\_\_\_\_
Subscriber's
Employer:\_\_\_\_\_
Contact #\_\_\_\_\_
Group #\_\_\_\_\_ Subscriber #\_\_\_\_\_

ASSIGNMENT AND RELEASE

Please list names of family members with whom you would like us to share your medical records:

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I agree to be financially responsible for this account and guarantee payment of all charges, whether or not paid by insurance, including any rebilling fee that accrues on such charges. I assign directly to Mid-America Audiology Group, Ltd. all insurance benefits, if any, otherwise payable to me for services rendered. I further understand and agree that if Mid-America Audiology Group, Ltd. places my account with an attorney or collection agency to obtain payment, I will be responsible for payment of any related fees, including attorney fees, court costs, process service fees, and any other reasonable expenses incurred by Mid-America Audiology Group, Ltd.

**Signed:**-----

**Date:**-----

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