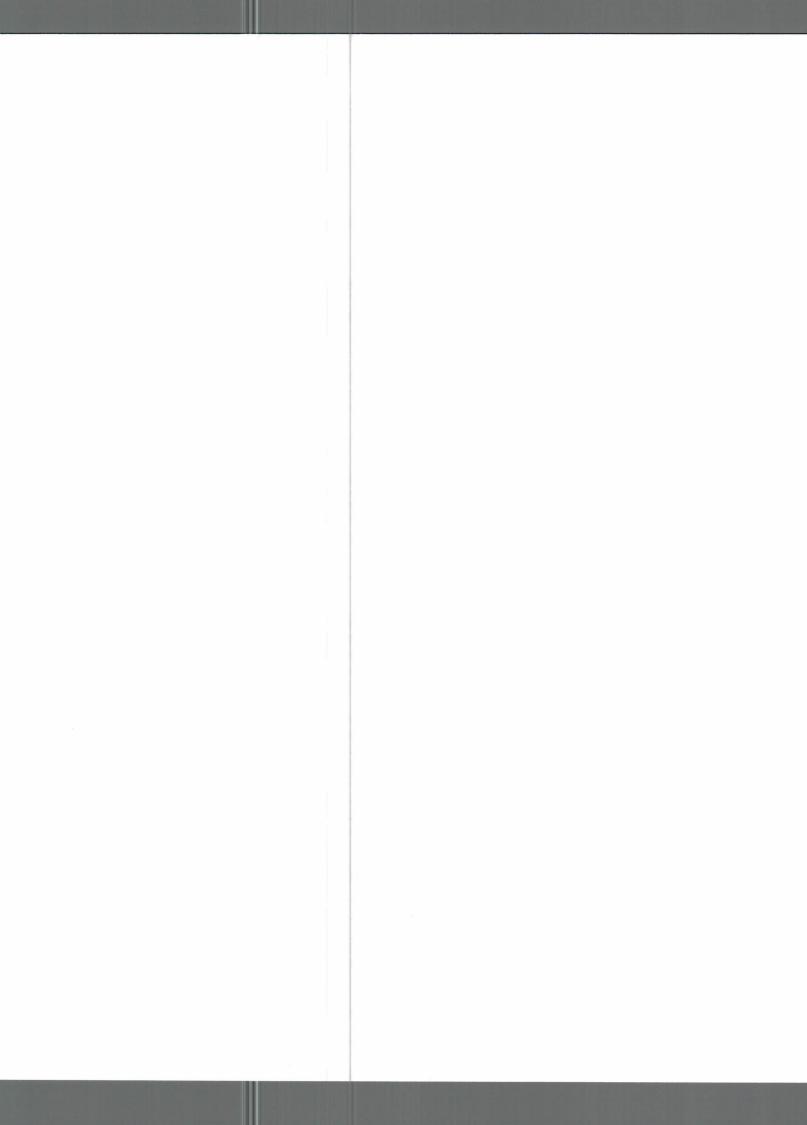
First NameMI_	Last	Date of Birth			
Address:	City	State Zip Code			
Primary Phone	Secondary Phone	Sex: M F			
Email:	Social Security Numi	ber:			
Marital Status: Married Divorced Single	Widowed				
Employer:	Primary Care Physician				
Emergency Contact					
Responsible Party (if other than Self)					
First Name:MILast _	Relationship to pa	atient			
Address (if different than above)					
Primary PhoneDate	of Birth				
Primary Insurance Coverage					
Secondary Insurance Coverage		·			
Insurance Authorization and Assignment: I hereby authorize Premier Hearing and Balance, LLC. to provide all necessary information to insurance carriers. I assign to Premier Hearing and Balance, LLC all payments for audiological services rendered for me or my dependents. I understand that my insurance coverage is an agreement between myself and my carrier and that I am responsible for any amount not covered by my carrier. I understand that it is my responsibility to obtain benefit and coverage information prior to services being rendered. By providing my email address and choosing yes, I am agreeing to receive educational and promotional messages from Premier Hearing and Balance, LLC. I understand that I can opt-out at any time.  Signature  Relationship if not patient					
Signature					
Date	Relationshi	p if not patient			
PAT:  I understand that, under the Health Insurar privacy regarding my protected health informulation of Conduct, plan and direct make involved in that treatments of the Conduct of the C	Relationshi  IENT PRIVACY CONSENT I  nce Portability & Accountability Act rmation. I understand that this info ny treatment and follow-up among ent directly and indirectly. I-party payers. I	FORM of 1996 (HIPAA), I have certain rights to ormation can and will be used to: the multiple health care providers who may ments and physician certifications. In the multiple health care providers who may ments and physician certifications. In the uses and use the second privacy Practices from time allow to obtain a current copy of the Notice is thow my private information is used or stand that you are not required to agree to a restrictions. I understand that I may			
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Date:				
	Medication	s List		
Patient Name:			DOB:	
1	MEDICATION ALLERGIES: List all	medications you are a		· · · · · · · · · · · · · · · · · · ·
×				
Medication	Type of reaction, such as a rash			
name	or breathing difficulties			
		•		
	PRESCRIPTION I	MEDICATION	T	T
Medication	Prescribing doctor's name	Reason for taking	Dosage	How often?
name	. roserizing design o name	the medication	Doouge	now orten:
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NC	DNPRESCRIPTION MEDICATIONS,	VITAMINS, and SUP	PLEMENTS	
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Medication	Reason for taking the medicine	Dosage	How often?	
name				
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