



**NARDELLI AUDIOLOGY**  
HEAR BETTER. LIVE BETTER.

111 STEELE STREET BRIDGEPORT  
PHONE: 304-842-9482  
FAX: 304-842-6775

DATE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_  
E-MAIL: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
SEX: \_\_M\_\_F AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ EMPLOYMENT STATUS: \_\_\_\_\_  
STUDENT: \_\_YES \_\_NO MARITAL STATUS: \_\_\_\_\_  
PRIMARY CARE/REFERRING PHYSICIAN: \_\_\_\_\_

SPOUSE (or responsible parties name): \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  
SPOUSE SOCIAL SECURITY #: \_\_\_\_\_

NAME OF PRIMARY INSURER: \_\_\_\_\_ PLAN NAME: \_\_\_\_\_  
ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

NAME OF SECONDARY INSURER: \_\_\_\_\_ PLAN NAME: \_\_\_\_\_  
ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

HOW DID YOU LEARN OF OUR PRACTICE?  
\_\_TIMES WV \_\_EXPONENT TELEGRAM \_\_RADIO \_\_TELEVISION  
\_\_PATIENT REFERRAL \_\_DIRECT MAIL \_\_OTHER: \_\_\_\_\_

I, \_\_\_\_\_ understand that I am ultimately responsible for the balance on my account for any professional services rendered. As a courtesy to our patients, we will submit claims to your insurance company when you pay your deductible and estimated co-payment now and sign the assignment of benefits form. MEDICARE CLAIMS cannot be submitted without a referring physician. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

I have been made aware of and offered a copy of the Privacy Act passed by the government in 2006.

\_\_\_\_\_  
Signature of Patient/Guardian Date