NARDELLI AUDIOLOGY
HEAR BETTER. LIVE BETTER.

620 ROSEBUD PLAZA
PHONE: 304-622-9428
FAX: 304-326-3430

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 REFERAL __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 out 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