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