TREASURE VALLEY
Hearing & Balance
Hear Well. Live Well.

Legal Name _____ DOB ____/____/____
First MI Last mm dd yyyy

Preferred Name _____ Age _____ Sex M F

Home phone (_____) _____ Cell phone (_____) _____ Work phone (_____) _____

Email address _____ SSN _____ _____ _____

Which method of communication do you prefer ☐phone call ☐email ☐text

Mailing address _____
Street City State ZIP

Employment Status ○Full Time ○Part Time ○Retired ○N/A Occupation _____

Marital status ☐ Married ☐ Single ☐Widowed

Spouse name _____ DOB ____/____/____
First MI Last mm dd yyyy

Name of responsible party if not self _____ DOB ____/____/____
First MI Last mm dd yyyy

Emergency contact _____ Phone # _____

Relation to patient _____

How did you hear about us? ○ Mail ○ Newspaper ad ○ Promotional call ○ Radio ○ Insurance

○ Yellow pages ○ Sponsored event ○ Seminar ○ Health/Senior fair ○ Website ○ Employer

○ Referred by friend _____ ○ referred by physician _____

○ Other _____

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Please read carefully and sign below.

_____I give permission to Treasure Valley Hearing & Balance to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

Additionally, you may discuss my hearing health care with the following individuals:

_____

_____

_____

_____I authorize Treasure Valley Hearing and Balance to notify me either by mail, email, text or phone of upcoming events, special promotions, new products, and other services and information.

_____I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give Treasure Valley Hearing & Balance permission to treat my concerns.

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original) Date

Signature of Parent or Guardian Date

Patient Insurance Form

Insurance Information

Some of our services are covered by insurance. If you did not give us insurance information when scheduling your appointment but would like us to bill your insurance, please fill out the following information.
If you do not want us to bill your insurance, no need to fill this out.

Primary Insurance _____

Subscriber's name _____ DOB ____/____/____
First MI Last mm dd yyyy

Subscriber's address _____ Home phone # _____

Subscriber's SSN _____ Group # _____ Policy # _____

_____

Occupation _____ Employer _____

Employer address _____ Employer phone # _____

Patient's relationship to subscriber ○ Self ○ Spouse ○ Child ○ Other

If you have a secondary insurance, please fill out the information below:

Secondary Insurance _____

Subscriber's name _____ DOB ____/____/____
First MI Last mm dd yyyy

Subscriber's address _____ Home phone # _____

Subscriber's SSN _____ Group # _____ Policy # _____

_____

Occupation _____ Employer _____

Employer address _____ Employer phone # _____

Patient's relationship to subscriber ○ Self ○ Spouse ○ Child ○ Other

Patient Signature (A copy of this signature is as valid as the original) Date