Welcome

Pediatric Patient Intake

To be completed by parent or legal guardian

Patient Personal Information

Child's Name: _____ Date of Birth: _____ Gender: F M

Names of Parents or Legal Guardians: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone Number: _____ Parent's Work or Cell Number _____

How did you hear about us / Referred by: _____

Siblings (Names & Ages) at home: _____

Name of Child's School, Pre-School, or Child Care Setting: _____

Whom may we speak with regarding your child's care? _____

Please let us know to whom we may send a report of today's results:

Physician/Pediatrician: _____ Teacher/School Audiologist: _____

ENT or other specialist: _____ Other: _____

Insurance Information

Insurance Carrier: _____ Employer: _____

Insured's Name: _____ DOB: _____ S.S. # _____

ID Number:_____ Group Number: _____ Relationship to Insured: _____

Secondary Insurance: Yes/No, if yes, carrier information: _____

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company above and assign directly to Accent on Hearing, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. Delinquent accounts can be charged an interest rate of 1.5% of the unpaid balance and all costs incurred by Accent on Hearing, Inc., in collecting such payment, including attorney's fees and court costs. I hereby authorize Accent on Hearing, Inc., to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____