Audiologic Solutions
www.audiologicsolutions.org
518-283-6111

PATIENT INFORMATION FORM

Date: ________________

Patient Name: ____________________________________ **DOB:** _______________

If patient is under 18:
Legal Guardian Name ____

Address: ____

City **State** **Zip**

Home Phone:_______________________ **Work Phone:**___________________

Cell Phone:_________________________ **EMAIL:**______________________________________

Would you like to receive our quarterly newsletter: **YES:** *Mail* *E-mail* **NO**

Circle one: *Married* *Widowed* *Single* *Divorced* *Student*
Circle one: *Male* *Female*

Primary Care Physician:________________________________ **Phone**:___________________

ENT Physician:____

Who Referred you to our practice: *please circle all that apply:*
Name of Person:____________________________________

Friend	Primary Care Doctor	ENT physician	Walk-In
Website	Health/Senior Fair	Employer	phone book
Attended Seminar	Newspaper	Radio	Mail

General History:

Primary Reason for Appointment: Tinnitus Hearing Sound Sensitivity Other

Secondary Reason for Appointment: Tinnitus Hearing Sound Sensitivity Other

Medications: Date: ***REPORT:*** ***G8427*** ***if filled completely*** ***or G8428*** ***if no meds taken***
G8428 ***if Route is not filled in***

Drug Name	Dose	Frequency	Route (oral, topical)	What for?

Rensselear, Hudson

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INSURANCE:

Provide your Ins. Cards and Photo ID to staff at check in.

It is your responsibility to know whether we are a participating provider. Please call the number on the back of your card. Our Tax ID # is 20-1672788 Provider: Dr. Erin Walborn

ABN: *I understand that no insurance company will pay for tinnitus retraining therapy. I agree to pay for this if I am being seen for tinnitus. The charge will be quoted at the time of service.* *YES* *NO*

I understand very few insurance companies will pay for earwax removal if done by an audiologist. If this is required, you may be asked to pay for the service. The fee will be quoted at time of service: *YES* *NO*

I understand MEDICARE will not pay for routine testing. I choose to pay for this service. *YES* *NO*

I understand most insurance companies do not pay for hearing aid related services. I choose to have these services done anyway. *YES* *NO*

____ ____________________
Patient/Guardian Signature *Date*

Primary Insurance:

Insurance Company Name:____
ID Number:____________________________ Group # ________________________
Policy Holder:_______________________________________ DOB:___________
Patient Relation to Insured: *Self* *Spouse* *Child*
Address *(if different than above):*____

Secondary Insurance

Insurance Company Name:____
ID Number:____________________________ Group # ________________________
Policy Holder:_______________________________________ DOB:___________
Patient Relation to Insured: *Self* *Spouse* *Child*
Address *(if different than above):*____

Third Insurance:

Ins. Co. Name:____________________ ID #_____________________
Policy Holder:_______________________________________ DOB:_____________
Patient Relation to Insured: Self Spouse Child

By signing below, I acknowledge that I have had access to read and review the HIPPA Policy of this office. I give permission for written and verbal information contained in my medical record to my insurance company or other health care providers, and attorneys. I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the above information is true and correct to the best of my knoweledge.

____
Patient Signature/Legal Guardian Date: