WELCOME

Date _____

Name _____ Age _____ Date of Birth _____

Address _____ Sex _____

City _____ State _____ Zip Code _____

Home Ph# _____ Work Ph# _____

Email Address _____ Employer _____

Primary Insur. _____ Secondary Insur. _____

Spouse's Name _____ Date of Birth _____

Spouse's Employer _____ Ph# _____

If patient is under the age of 18, please give:

Mother's Name _____ Wk Ph# _____

Father's Name _____ Wk Ph# _____

Nearest relative not living with you _____

Relationship _____ Ph# _____

Have any family members been seen here? **YES** ☐ **NO** ☐

Name _____ Ph# _____

Chief Complaint _____

Do you currently wear hearing aids? _____ If yes, what type _____ Year _____

Primary Care Doctor _____ Ph# _____

Do you wish us to send results to this physician? **YES** ☐ **NO** ☐

How did you hear about us? Online ☐ Insur. Provider ☐ Friend ☐ Dr. Referral ☐

Other _____

Assignment Of Benefits-Release Of Information

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, and any other health plans to Luhn Hearing Care, LLC,. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment.

Signature _____

Guardian's Signature _____
If patient is under 18yrs