Associates In Hearing Health Care
121 Clements Bridge Road
Barrington, NJ 08007
856-546-1535

Patient Information

Patient's Name _____
First Initial Last

Responsible Party (if patient is a child, Parent or Guardian) _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____ **Mobile Phone** _____ **Primary:** ☐ H ☐ W ☐ M

Social Security # _____ **Date of Birth** _____ **Sex** M F (circle) **Email** _____

Marital Status Married Single Other (circle) **Employment Status** FullTime PartTime None (circle) **Student Status** FullTime PartTime None (circle)

Referring Physician _____ **Primary Physician** _____

Is there a place/physician we can send a copy of your test results? _____

Emergency Contact _____ **How did you hear about us?** _____

How would you like to receive Appointment Notifications? ☐ Telephone ☐ Text ☐ Email ☐ None

Primary Insurance Information

(if patient is also the insured, enter 'SAME' for name & address) *(Office only): Insurance Card copy on file?* _____

Insured's Name _____
First Initial Last

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____

Patient Relation to Insured Self Spouse Child Other (circle) **Insured Date of Birth** _____ **Insured Sex** M F (circle)

Insured Employment Status FullTime PartTime None (circle) **Insured Employer** _____

Insurance Co. Name _____ **Subscriber ID Num** _____ **Group Num** _____

Other Insurance Information

(if patient is also the insured, enter 'SAME' for name & address) *(Office only): Insurance Card copy on file?* _____

Insured's Name _____
First Initial Last

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____

Patient Relation to Insured Self Spouse Child Other (circle) **Insured Date of Birth** _____ **Insured Sex** M F (circle)

Insured Employment Status FullTime PartTime None (circle) **Insured Employer** _____

Insurance Co. Name _____ **Subscriber ID Num** _____ **Group Num** _____

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signed _____ **Date** _____