ADVANCED AUDIOLOGY INSTITUTE
7660 West Cheyenne Avenue, Suite 114
Las Vegas, NV 89129
t 702•823•7986 f 702•880•1511

Patient Name: _____
LAST FIRST MI

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Date of Birth: _____ SS#: _____ Other Phone: _____

Male Female Single Married Divorced Widowed Separated

Patient's Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Work related injury: Yes No Auto Accident: Yes No Date of injury: _____

Emergency contact: _____ Relationship: _____

Advanced Directive: Yes No Copy on file: Yes No Retired: Yes No

Referred by: _____

IF DIFFERENT FROM ABOVE – POLICY HOLDER / INSURED INFORMATION – PRIMARY INSURANCE

Insured Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS#: _____

Employer: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ Phone: _____

Group #: _____ Policy #: _____

SECONDARY INSURANCE INFORMATION

Insured Name: _____

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

Date of Birth: _____ SS#: _____ Phone: _____

Secondary Insurance: _____ Phone: _____

Group #: _____ Policy #: _____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance company and I assign benefits to Heppler Audiology PLLC dba Advanced Audiology Institute. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time services are rendered. We cannot guarantee payment to Heppler Audiology PLLC dba Advanced Audiology Institute. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Heppler Audiology PLLC dba Advanced Audiology Institute. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the court or outside collection agency.

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records if necessary.

SIGNATURE: _____ **DATE:** _____