2913 Corporate Circle, Suite 300, Flower Mound, TX 75028
Phone 817-997-4084
Fax 817-333-1190
www.flowermoundfamilyhearing.com

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____

City, State and Zip: _____

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ SSN: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Employment Status: Full Time ❑ Part Time ❑ Student ❑ Retired ❑ Sex: Male ❑ Female ❑

Marital Status: Single ❑ Married ❑ Widowed ❑ Divorced ❑

Referring Physician: _____ Primary Physician: _____

Insurance Information

Primary Insurance:

Plan Name: _____ Policy/ID#: _____ Group #:_____

Subscriber's Name: _____ Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Secondary Insurance

Plan Name: _____ Policy/ID#: _____ Group #:_____

Subscriber's Name: _____ Patient Relationship to Subscriber: _____

Subscriber's DOB: _____ Subscriber's Employer: _____

Guarantor Information-Person responsible for payment for services rendered by Family Hearing Practice.

Guarantor Name: _____

Address: _____ Phone: _____

City, State and Zip: _____

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical and surgical benefits to Family Hearing Practice, PLLC. **I also agree to abide by Family Hearing Practice 24 hour cancellation policy and understand that I may be charged between $35 and $100 if proper notification is not given.**

_____ _____

Signature of Patient or Guardian Date