Hearing Solutions of Arizona

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7525 E. Broadway Rd., Suite 7
Mesa, Arizona 85208
Fax 480-833-1902

Referred By:_____ **Primary Care Physician:** _____

Name: _____ Birthdate: _____ Date: _____

Address: _____/_____/_____/_____
City State Zip Code

Home Phone: _____ Work Phone: _____

Social Security # _____ Employer: _____

Spouse Name: _____ Birthdate: _____

Spouse Employer: _____ Social Security # _____

IF PATIENT IS A MINOR: Parent Name:_____

Address: _____ Social Security # _____

Home Phone: _____ Work Phone: _____ Employer: _____

Primary Ins: _____

Insured Name: _____

Insured Birthdate: _____

Member ID # _____

Group # _____

Ins. Address: _____

Secondary Ins: _____

Insured Name: _____

Insured Birthdate: _____

Member ID # _____

Group # _____

Ins. Address: _____

I, the undersigned, authorize the release of any medical information necessary to process my insurance claims. I authorize payment of the insurance benefits to Hearing Solutions of Arizona, L.L.C. for the services rendered. I understand that I am responsible and agree to pay for any charges or balance not covered by my insurance carrier.

Patient Signature: _____ **Date:** _____
Lifetime Signature

Parent or Guardian Signature:_____ **Date:** _____
Lifetime Signature

Relationship to Patient : Mother Father Guardian (Circle One)