State Hearing and Audiology, P.C., 6609 State Route 56, Suite 11, Potsdam, NY 13676 Phone-315-508-4327, FAX-315-262-0300, Email: statehearing@yahoo.com
Jon D. Suarez, M.S., F/AAA Federal ID#: 46-1581092

PATIENT INFORMATION

Patient Name:_____DOB:_____
Last First Middle (MM/DD/YYYY)

Mailing Address:_____
Street/P. O. Box City State Zip Code

Physical Address:_____

Home Phone #:_____ Cell Phone #: _____

Work Phone #:_____ Email: _____

Responsible Party:_____DOB:_____
Last First Middle (MM/DD/YYYY)

Mailing Address:_____
If Different than above Street/P.O. Box City State Zip Code

Marital Status: Married ____Single ____Widowed ____Divorced ____Civil Union _____

Gender: Male ____Female _____ Age: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Company:_____

Subscriber ID #:_____ Group #: _____

Subscriber Name: _____ DOB:_____

Relationship to Patient: _____

Secondary Insurance

Insurance Company:_____

Subscriber ID #:_____ Group #: _____

Subscriber Name: _____ DOB:_____

Relationship to Patient: _____

Primary Care Physician:_____ Phone #:_____

Address: _____

_____

Assignment and Release of Information Statements:

I hereby authorize the release of information in relation to medical treatment by State Hearing and Audiology, P.C. to the health insurance carriers, or others who are financially liable for my medical care and all information needed to substantiate payment of such medical care and permit representatives thereof to examine and make copies of all records in relation to such care and treatment.

I hereby assign to State Hearing and Audiology, P.C. sufficient monies and/or benefits to which I may be entitled from government agencies, health insurance carriers or to other who are financially liable for my medical care to cover the cost of the care and treatment rendered to myself or my dependent.

Patient/Guardian Name (Please print)_____

Patient/Guardian Signature _____Date _____