ADVANCED Hearing Centers *Advanced Hearing Center*

Phone: 719-632-3100
Fax: 719-442-0887

bkkeeper@ahear.com 3225 Austin Bluffs Pkwy Ste150 - Colorado Springs, CO 80918

Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone: _____ Cell:_____

Work Phone: _____ Cell Phone Carrier: _____

Mailing Address (Street) _____

City _____ ST _____ ZIP_____

Email Address: _____

Spouse/Family Member: _____ Phone # _____

Preferred Method of Contact: EMAIL or MAIL

Whom may we contact in case of an emergency? _____ Phone #_____

How did you hear about us? _____

Primary Ins. _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth_____

Secondary Ins._____ _____ Insurance ID# _____

Who is financially responsible for this visit? _____ Phone # _____

I will pay today by Cash _____ Check _____ Credit Card _____ Other # _____ ___

I authorize Advanced Hearing Center to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Advanced Hearing Center of any changes in my health status or in the above information.

Signature _____ Date _____