Marietta Hearing Center
990 Whitlock Ave., N.W., Suite D
Marietta, GA 30064
(770)427-3033, (770) 427-3035 (fax)

NAME: ____

ADDRESS: ____

CITY: ____________________________ STATE ________ ZIP CODE: ___________________

HOME PHONE: ______________________________ WORK PHONE: _______________________________

CELL PHONE: _______________________________

DOB: __________________________ MARITAL STATUS _____________________

SPOUSE NAME: ____

EMAIL: ____

PRIMARY INSURANCE POLICY HOLDER NAME (IF OTHER THAN PATIENT): ______________________________

POLICY HOLDER SSN: __________________________ DOB: __________________

RELATIONSHIP TO PATIENT: _____________________

SECONDARY INSURANCE POLICY HOLDER NAME (IF OTHER THAN PATIENT): ___________________________

POLICY HOLDER SSN: __________________________ DOB: __________________

RELATIONSHIP TO PATIENT: __________________

EMERGENCY CONTACT: ___________________________________ PHONE: ______________________

RELATIONSHIP TO PATIENT: ________________________

FAMILY PHYSICIAN: ____ PHONE : ______________________

I understand that I will be responsible for any balance or charges that are not covered by my insurance. If I have a co-payment with my insurance, it is payable at the time services are rendered. If I do not have insurance to cover audiology services, I am solely responsible for the charges and it is payable when services are rendered. All returned checks will be assessed a $30.00 fee. The check amount and the fee are due within 10 days from notification.
I have read, understood and agree to the financial policies above.

Patient/Responsible Party ____________________________________ Date: _____________________