LAKESIDE AUDIOLOGY
(240) 318-5092

10401 Hospital Drive, Suite G4
Clinton, MD 20735

PATIENT INFORMATION

PATIENT DATA

Last Name _____ First Name _____ MI _____

Birth Date _____ Gender _____

Address: (Street) _____

City _____ State _____ Zip Code _____

Phone Number: Home Phone _____ Cell phone _____

Email Address _____

Employed By/Current Occupation _____

Whom may we thank for referring you to our office? _____

IN CASE OF EMERGENCY

Name _____ Relationship _____

Phone Number: Home Phone _____ Cell phone _____

INSURANCE INFORMATION

Primary Insurance _____ Insurance ID# _____

Name of Policy Holder _____ Policy Holder's Date of Birth _____

Secondary Insurance _____ Insurance ID# _____

Name of Policy Holder _____ Policy Holder's Date of Birth _____

FINANCIAL INFORMATION

Who is financially responsible for this visit? ☐ Self ☐ Other:

Name _____ Phone _____

I will pay today by ☐ Credit Card ☐ Check ☐ Cash ☐ Other _____

I authorize LAKESIDE AUDIOLOGY to release information requested with regard to processing my claims.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. 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 LAKESIDE AUDIOLOGY of any changes in my health status or changes to the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____