Appalachian Hearing and Speech Center

423-328-9190
Fax: 423-328-9189

www.apphsc.com info@apphsc.com 306 Sunset Drive Suite 103 - Johnson City, TN 37604

Patient Information Form

Last Name _____ First Name _____ MI _____

Birth Date _____ Sex _____ Home Phone # _____ Cell# _____

Social Security #_____ Social Security # of Guardian (if minor)_____

Mailing Address (Street) _____

City _____ ST _____ ZIP_____

Email Address:_____Preferred Name_____

Nearest Relative: _____ Phone # _____

Your Employer _____ Phone #_____

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

Whom may we thank for referring you? Physician Newspaper Sign Phonebook Friend Family Member
Name of referral source: _____

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 # _____

If you were a previous patient, how did you find out about our new office? _____

Name and address of Physician:_____

I authorize Appalachian Hearing and Speech 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 Appalachian Hearing and Speech Center of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____