PHONE: 610-601-6000
FAX: 610-545-4722
Tony@DevonHearing.com

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237 W. Lancaster Avenue, Suite 116, Devon, PA 19333 DevonHearing.com

Please complete the information below and sign.

First Name: ____________________ Last Name: __________________________

Date of Birth: ___________________ Age: ___________ Gender: ___________

Address: _______________________ City: ________________ Zip: _________

Home phone number: ______________ Cell phone number: _______________

Email: ____________________________ Spouse's Name: ___________________

Primary Care Physician: ____________ Referring Physician _______________

How did you hear about Devon Hearing? ______________________________

PERSON RESPONSIBLE FOR BILL (if other than patient) ______________________

PERSON TO CONTACT IN CASE OF EMERGENCY (different from patient)

Name: _____________ Relationship _______________ Phone: _____________

Address: ____

INSURANCE INFORMATION

Insurance Company: ____

Please present your insurance card(s) and a photo ID to the front desk.

I assign all medical benefits to which I am entitled, under private insurance, or any other health plan. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, copayments and annual deductibles.

__________________________________ ________________________

Signature **Date**