AUDIOLOGY
OF NASSAU COUNTY PLLC

516-ALL-HEAR (255-4327)
www.audiologyofnassau.com
165 North Village Avenue
Suite 114
Rockville Centre, NY 11570

Patient Information Form

Patient Name _____ DOB ___ / ___ / ___
Title First M Last mm dd yy

Mailing Address _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Email Address _____ Sex ☐ M ☐ F

Retired? ☐ Y ☐ N Occupation _____
If retired, prior occupation

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse/Partner Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.
If the insurance is NOT under your name, please complete this section.

Name of Subscriber _____
First MI Last

DOB ___ / ___ / ___ Relationship _____
mm dd yy

Primary Care Physician _____ Phone # _____
First MI Last

Referring Physician _____ Phone # _____
First MI Last

How did you hear about us?

☐ Mail ☐ Website ☐ Insurance
☐ Yellow Pages ☐ Educational Class ☐ Event
☐ Physician Referral _____
First MI Last
☐ Referred by Friend _____
First MI Last

For internal use only: Medical Group Specialty

Name _____ Group _____ Insurance Affiliation _____

Please read carefully and sign below.

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy at this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give Audiology Associates permission to treat my concerns.

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original.)	Date