Comprehensive Hearing Services

2626 Winne Ave. Helena, MT 59601 (406) 443-8838 **www.comphearing.com**

Basic Information:

Patient First Name_____ MI_____ Last_____

Preferred First Name_____ DOB _____/_____/_____ Gender: Male or Female

SS# _____/____ /_____ How did you hear about us? _____

Referring Physician _____ Primary Physician_____

Guardian/Spouse_____ Relationship _____ Phone _____

Status: Child/Minor Single Married Divorced Widowed Partner

Occupation _____ Employer_____

Employment Status: Full-time / Part-time / Self-Employed / Not-Employed / Retired / Student

Contact Information: *Check preferred contact method

○Home Phone_____ ○Cell_____ ○Work_____

○Send Text message ○E-mail Address _____

Primary Mailing Address _____

City _____ State _____ Zip code _____

Secondary Mailing Address _____

City _____ State _____ Zip code _____

Insurance: *DOB & SS# of policy holder

Primary_____ DOB _____/_____/_____

Secondary_____ SSN # _____/_____/_____

Patient Acknowledgement:

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices/Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

We will submit your insurance claim and allow your insurance company 60 days to process. I understand and agree that regardless of my insurance status, the claim for insurance payment and/or the balance of my account is my responsibility. This includes, but is not limited to, purchases or professional services 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 Comprehensive Hearing Services permission to treat my concerns. I understand that this consent will be valid and remain in effect as long as I receive audiological care at Comprehensive Hearing Services.

I have read and understand all the above information.

Signature_____ Date _____