

**Professional Speech & Hearing Specialists**

40 S.W. 12th Street, Ste B-202 & C-201  
Ocala, Florida 34471  
(352) 351-3977

PLEASE PRINT

PATIENT NAME: \_\_\_\_\_  
FIRST MIDDLE LAST

ADDRESS: \_\_\_\_\_

\_\_\_\_\_ CITY STATE ZIP

HOME #: \_\_\_\_\_ BUS # \_\_\_\_\_ CELL # \_\_\_\_\_

\*E-MAIL ADDRESS: \_\_\_\_\_

BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_ SEX \_\_\_ MARITAL STATUS \_\_\_\_\_

SOC. SEC. # \_\_\_\_\_ EMPLOYMENT STATUS \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

SPOUSE OR PARENTS NAME: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY CARRIER \_\_\_\_\_ SECONDARY CARRIER \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_

BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ If other than self, holder's relationship **SPOUSE PARENT OTHER**

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or the party who accepts assignment. I HEREBY AGREE TO PAY ANY CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

I plan to make payment of my medical expenses as follows: \_\_\_ Cash/Check \_\_\_ Credit card

SIGNED: \_\_\_\_\_ DATE \_\_\_\_\_

\*OFFICIAL OFFICE BUSINESS ONLY

Verified driver's license \_\_\_\_\_  
Initials