South Springs Plaza
7614 E. 91st Street, Suite 160
Tulsa, OK 74133
(918) 493-3133

Patient Information Form

Last Name_________________________First Name________________________MI___________
Mailing Address (Street)____
City_______________________________________State_________Zip Code___________________
Birth Date__________________Sex__________Home Phone#______________Other_________
Marital Status: Married______Single________Widow_______Other_________
Social Security#____________________Social Security# of Guardian (if Minor)___________
Employed By____________________________________Employer Phone#_________________
Who is financially responsible for this visit?____
________Relationship to Patient__________________________________DOB:________________
Address___________________________________City_________________State_________Zip____
Referring or Primary Care Physician:__________________________________Phone________
Emergency Contact Person______________________________Phone______________________

Purpose of Visit____
Whom may we thank for referring you to our office?____________________________________

Primary Insurance Company____________________________Insurance ID________________
Name of Policy Holder____________________________Policy Holder DOB________________
Policy Holder SSN_________________________________Relationship to Patient____________
Secondary Insurance Company__________________________Insurance ID________________

I will pay today by Cash__________Check________Credit Card__________Other_________

AUTHORIZATION TO EVALUATE, RELEASE OF INFORMATION AND INSURANCE ASSIGNMENT

I hereby authorize Audiology Doctors of Tulsa, PLLC to evaluate and release any and all information concerning medical treatment rendered to the patient named herein to any insurance company or government agency making payments for medical services rendered and to any doctors or health care provider who are involved in the patient's care. "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)." I also authorize assignment of all insurance benefits to Audiology Doctors of Tulsa, PLLC. I understand that I am responsible for payment for all medical services not covered by an authorization between Audiology Doctors of Tulsa and my insurance company.

X Signature____Relationship______________________Date_____________

ACKNOWLEDGEMNET OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In order to comply with new federal HIPAA regulations and to insure the privacy and confidentiality of you health information, Audiology Doctors of Tulsa is providing you with our Notice of Privacy Practices. I acknowledge that I have received a copy of this Notice.

X Signature____Relationship______________________Date_____________