



**Carson Audiology  
Associates**

Name \_\_\_\_\_ M \_\_\_ F \_\_\_ Date \_\_\_\_\_

Last

First

MI

Mailing Address \_\_\_\_\_  
Street City State Zip Code

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ Married/Single/Widowed

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Student Status Fulltime/Part/None

Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Employed Yes/No Where \_\_\_\_\_ Work Phone \_\_\_\_\_ Fulltime/Parttime

Primary Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Email address \_\_\_\_\_ May we send you emails? YES/NO

Please tell us how you heard about our office \_\_\_\_\_

**Person Responsible for Account**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First MI

Mailing Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Primary Insurance**

Insurance Company Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Social Security # \_\_\_\_\_

**Secondary Insurance**

Insurance Company Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Social Security # \_\_\_\_\_

**Assignment and Release**

I hereby authorize Nanci Campbell, Au.D. to release any information required by appropriate agencies or insurance companies for purposes of filing claims. I also authorize my insurance benefits to be paid directly to Dr. Campbell. I am financially responsible for any diagnostic services or assistive devices, including hearing aids, at the time of purchase and any appropriate co-payments and deductibles. We will bill your insurance for you, as a courtesy, but our relationship is with you, not your insurance company.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_