

UNCG SPEECH AND HEARING CENTER
PATIENT INFORMATION FORM

FILL OUT ALL INFORMATION. PLEASE PRINT. THANK YOU.

HAVE YOU BEEN HERE BEFORE: _____ YES _____ NO

Patient Information:

PATIENT NAME: (First/Middle/Last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

TELEPHONE: home: _____ work: _____ cellular: _____

E-MAIL: _____

PATIENT SOCIAL SECURITY #: _____ - _____ - _____ BIRTH DATE: (Month/Day/Year) _____

GENDER: M F STATUS: Single Married Divorced Widowed Other _____

SPOUSE NAME: (First/Middle/Last) _____

PATIENT'S EMPLOYER (if applicable): _____ UNCG STUDENT? Part Time Full Time

CONDITION RELATED TO: Employment Auto Accident Other Accident State (where accident occurred): _____ and when/date: _____

If Patient is a CHILD/DEPENDANT, Complete The Following:

CHILD/DEPENDANT LIVES WITH: Both Parents Father Mother Guardian

RELATION TO CHILD/DEPENDANT: _____ YOUR NAME: (First/Middle/Last) _____

YOUR ADDRESS: (Check box if all same as above) _____

TELEPHONE: home: _____ work: _____ cellular: _____

E-MAIL: _____ YOUR SOCIAL SECURITY #: _____ - _____ - _____

Insurance Information –COPY OF (BOTH SIDES OF) THE VALID INSURANCE/MEDICAID CARD/S AND PRIMARY DOCTOR'S ORDER/REFERRAL FOR MEDICAID PATIENTS AND OTHERS IF APPLICABLE REQUIRED BEFORE THE SERVICES ARE RENDERED:

NAME OF INSURANCE COMPANY: _____ TELEPHONE: _____

CLAIMS ADDRESS: _____

NAME OF POLICY HOLDER: (First/Middle/Last) _____

EMPLOYER: _____ ID #: _____ DOB OF POLICY HOLDER: _____

GROUP POLICY #: _____ SOCIAL SECURITY #: _____ - _____ - _____

DO YOU HAVE A SECONDARY HEALTH CARE PLAN? Yes No

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I acknowledge that I am personally responsible for any charges including, but not limited to, collections and attorneys' fees and costs, incurred in connection with services I receive at the UNCG Speech & Hearing Center regardless of Workman's Compensation, referral source or preauthorization. Medicaid, Blue Cross Blue Shield, Partners, State of NC Members agree to pay for any service performed without a valid referral, preauthorization/ pre-approval and after denial of approval of services. Workers' Compensation Clients must provide their attorney's and agent contact numbers and authorize UNCG Speech & Hearing Center to discuss the case with them. I authorize the release of any and all information concerning medical history, physical condition, diagnostic, and/or treatment information necessary to process any claims made. I give my permission to transmit information about my case electronically. I also authorize payment of medical benefits to UNCG Speech & Hearing Center for services rendered.

(Sign/Seal) _____ Date _____

self/ parent/ legal guardian ONLY