GARDEN STATE
HEARING & BALANCE CENTER

Date: _____

Patient Information:

Patient Name: _____Phone: (_____) _____-_____
First Middle Last

Patient Date of Birth: _____

Primary Care Physician: _____Phone #: _____

Spouse/Partner's Name: _____
First Middle Last Date of Birth

Mailing Address: _____

_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Referred by: ☐ Friend ☐ Physician ☐ Other-Please Provide: _____

Responsible Party Information: ***(If not the patient only)***

Name: _____Social Security Number: _____

Address: _____

Place of Employment: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ E-Mail Address: _____

Emergency Contact: _____Phone: _____

PLEASE PROVIDE INSURANCE CARD (S) AND DRIVER'S LICENSE TO FRONT OFFICE STAFF

**********PLEASE READ CAREFULLY- MARK BOXES AND SIGN BELOW**********

☐ I give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

☐ I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered. I agree that a collection fee of 40% of the amount due will be added to any unpaid balance after 90 days.

☐ I acknowledge that I have reviewed the Health Insurance Portability & Accountability Act (HIPPA) policy of this office. A copy has been provided to me upon request.
People authorized for this office to speak to regarding your account:
_____

☐ Detailed messages may be left on home and/or cell phones.

☐ Detailed messages may not be left on home and/or cell phones.

☐ I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give my AudigyCertified™ practice permission to treat my concerns.

I have read and understand all the above information.

_____ _____
Patient Signature- A copy of this signature is as valid as the original Date

_____ _____
If patient is a minor (under 18)- Signature of Parent or Guardian Date

Rate Your Experience:
We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas (you may also request confidential response card to be mailed to our third party management group):

Location and accessibility: ☐ Excellent ☐ Average ☐ Poor
Convenience of appointment times: ☐ Excellent ☐ Average ☐ Poor
Friendly Greeting: ☐ Excellent ☐ Average ☐ Poor
Clean and Welcoming Environment: ☐ Excellent ☐ Average ☐ Poor
Adequate Parking: ☐ Excellent ☐ Average ☐ Poor