EVERCLEAR HEARING PRODUCTS, LLC

Pattie Rogstad, H.I.S - Ted Mollerud, M.S.

Nicole Smith, AuD

PATIENT INFORMATION

Name (Last, First, M.I.) ______________________

Date of Birth ______________ Age __________

☐Male ☐Single ☐Married

☐Female ☐Divorced ☐Widowed

Address ______________________

City ______________________

Phone: ☐ Home ☐ Work ☐Cell ______________ Phone: ☐Home ☐Work ☐Cell ______________

State ______________ Zip Code ______________

Patient's Social Security Number ______________________

Patient's Employer ______________________

Patient's Email Address ______________________

Refered By M.D.: ______________________

Primary Care M.D.: ______________________

Referral Clinic: ______________________

Primary Clinic: ______________________

RESPONSIBLE PARTY

Name ______________________

Date of Birth ______________________

Address ______________________

Relationship ______________________

City ______________ State ______________ Zip Code ______________

Phone: ☐ Home ☐Work ☐Cell ______________ Phone: ☐Home ☐Work ☐Cell ______________

PRIMARY INSURANCE HOLDER INFORMATION

Primary Insurance Company ______________________

Policy Holder Name/Social Security Number ______________________

ID Number ______________ **Group Number** ______________

Date of Birth ______________ Relationship ______________

Employer Plan: ☐Yes ☐No

Employer ______________________

SECONDARY INSURANCE HOLDER INFORMATION

Secondary Insurance Company ______________________

Policy Holder Name/Social Security Number ______________________

ID Number ______________ **Group Number** ______________

Date of Birth ______________ Relationship ______________

Employer Plan: ☐Yes ☐No

Employer ______________________

Who may we thank for referring you to our clinic?

Physician____ Friend _____ Ins Comp ______ Phone Book _____ Family ______ Other ________