Aurora audiology

1901 Airport Rd., Suite 102
Fairbanks, Alaska 99701
p: 907-451-4327 | f: 907-451-4325
office@auroraaud.com
www.auroraaud.com

PATIENT INFORMATION SHEET

Full Name:	DOB: / /
Mailing Address:	
City:	State: Zip:
Home Phone: ( )	Cell Phone: ( )
Email Address:	
Employer:	Work Phone: ( )
Marital Status: ❒Single ❒Married ❒Other	Spouse's Name:
How did you hear about our clinic?	
Who is your Primary Care Provider?	
If different than the patient, NOT an insurance company Person Responsible for Payment	Relationship:
Emergency Contact:	
Phone: ( )	Relationship:

THIS SECTION MUST BE FILLED OUT IN ORDER FOR US TO FILE YOUR INSURANCE(S)

Primary Insurance: ❒YES ❒NO ❒SELF-PAY Secondary Insurance: ❒YES ❒NO

(Provide physical card to patient care coordinator)

I certify that the above information is true and correct to the best of my knowledge. Also, by signing below I am giving permission to leave messages about appointments and/or medical reports at the personal address, personal phone number, email address and/or spouse or responsible party contact information. (Mark out any that should not be included.)

I understand that I am financially responsible for all charges, regardless of insurance coverage.

Signature of Patient / Authorized Representative Date