

Dr. Nikki DeGeorge, Audiologist  
Welcome to Coweta Hearing Clinic

**PATIENT INFORMATION**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Date of Birth \_\_\_/\_\_\_/\_\_\_ Gender \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
SS Number \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

Occupation / School \_\_\_\_\_  
Employer / Parent's Employer \_\_\_\_\_

Spouse's / Parents Name \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Contact Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PHYSICIAN INFORMATION**

Primary Care Physician \_\_\_\_\_  
Primary Care Address/Location \_\_\_\_\_  
Referring Physician \_\_\_\_\_  
Referring Physician Address /Location \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_  
Group # \_\_\_\_\_ Co-Pay \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_  
Group # \_\_\_\_\_ Co-Pay \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

By signing below, I agree to be held responsible for all payments due, including any payments due after insurance has been filed. I also authorize Coweta Hearing Clinic to file insurance on my behalf for services rendered.

\_\_\_\_\_  
Patient (Guardian) Signature

\_\_\_\_\_  
Date