PATIENT INFORMATION

P: (212) 354-2360
F: (212) 354-2364
Email: info@nycears.com
www.NYCHearing.com

HEARING ASSOCIATES

110 West 40th Street
Suite 500
New York, NY 10018

160 West 18th Street
Ground Floor
New York, NY 10011

45 West 67th Street
Ground Floor
New York, NY 10023

Patient Name: _____ _____ _____ Date of Birth: _____
First M.I. Last

Address: _____ _____ _____ _____ _____ Age: _____
Street Apt City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone : _____ SS #: _____

Email: _____ Employer: _____

Sex: Male _____ Female ____ Emergency Contact: _____

Emergency Contact Relation: _____Phone # _____

Marital Status: Single ____ Married ____ Long-Term Commitment ____ Widow ____

PRIMARY Insurance Company: _____

Name of Insured :_____ Employer: _____
(Policy Holder)

Address (If different from above): _____ Insured D.O.B._____

SECONDARY Insurance Company: _____

Name of Insured :_____ Employer: _____
(Policy Holder)

Address (If different from above): _____ Insured D.O.B._____

Primary Care Physician: _____ Phone # _____

A copy of your Audiogram will be sent to your referring physician: (Initial) _____

Can NYC Hearing Associates leave a voicemail? Yes____ No____

Referral Source: _____ (i.e. Google, Physician, Audiologist)

Reason for Visit: _____

Privacy Practice Notice: According to government law , we are required to make available to you a copy of our privacy practice notice. Your signature below acknowledges your receipt of this notice:

Signature: _____ Date: _____