Thames Hearing Services, Inc.
324 Flanders Road
East Lyme, CT 06333
(860) 739-1864

Patient Name: ____
LAST FIRST MI

Date of Birth: ______________________
MONTH DATE YEAR

Home Address: ____
STREET TOWN STATE ZIP

Mailing Address: ____
(if different than above)

Primary Care Physician: ______________________________________
Referral Source: ____
Employer: ____

Preferred Phone #: ____________________
Secondary Phone #: ____________________
Email: ______________________________

INSURANCE INFORMATION:

Name of Subscriber: ____
LAST FIRST MI

Subscriber's Date of Birth: ______________________
MONTH DATE YEAR

Relationship to Patient: Self / Spouse / Parent or Guardian

Subscriber's Employer: _______________________________________

Primary Insurance: ____

Secondary Insurance: ____

*************ENSURE THAT WE COPY YOUR INSURANCE CARDS**************

CONFIDENTIAL COMMUNICATION REQUEST:
I prefer to be contacted in the following manner:
_____ Phone
_____ Text
_____ Email

Information may also be disclosed to:

NAME	RELATIONSHIP	PHONE

It is our policy to leave messages with pertinent information, if you prefer that we only leave a call back number please initial here: _______

I have read and understand the attached "Patient Financial Policy" and agree to its terms, as stated. I understand that by signing this form I am accepting financial responsibility for charges incurred.

RELEASE OF INFORMATION:

I authorize my health care provider, and their representatives, to release any information to any insurance carrier for the payment of any claim directly to: Thames Hearing Services, Inc.

_______________________________ SIGNATURE

_______________________________ DATE

Thames Hearing Services, Inc.
324 Flanders Road
East Lyme, CT 06333
(860) 739-1864

Name: ______________________________ **Date:** __________________

MEDICAL INFORMATION:

Please list any significant medical history:

____
____
____
____
____

MEDICATION LIST:

Include: Prescriptions, Over-the-Counter, Herbals and Vitamin/Mineral/Dietary Supplements	**Dosage:** (in mg)	**Frequency:** (daily/AM/PM)	**Route:** (Oral/Shot/ Patch)