Miller Audiology and Hearing Aid Dispensing, PLLC

214-696-9955
Fax: 214-696-9956

5445 La Sierra Dr, Suite 230 - Dallas, TX 75231

Patient Information Form

Last Name _____ First _____ MI _____

Date of Birth: _____ Home Phone # _____ Work Phone # _____

Mailing Address _____

City _____ State _____ Zip Code _____

Email address _____ Spouse Name _____

Whom may we thank for referring you? _____

Primary Care Physician Name _____

Primary Care Physician Phone # _____

Primary Insurance Company _____ ID# _____

Name of Insured _____ Insured Date of Birth _____

Insured relationship to you _____

Secondary Insurance Company _____ ID# _____

I will pay today by CASH _____ CHECK _____ MC/Visa/Discover _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

□ By checking this box and signing below, I acknowledge that I received a copy of Miller Audiology and Hearing Aid Dispensing, PLLC's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify **Miller Audiology and Hearing Aid Dispensing, PLLC** of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature (if minor) _____ Date _____