AUDIOLOGY OF TULSA

918-745-9052
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4564 S Harvard Ste A - Tulsa, OK 74135-2918

Patient Information Form

Salutation________Last Name___________________ First Name_________________ MI__________

Birth Date ____________ Sex _____ Home Phone: ________________ Cell:____________________

(If under 18) Parent/Guardian Name: ____

Mailing Address (Street) ____

City ______________________________________ ST ______________ ZIP____________________

E-mail Address: ____

Employer: _____________________________ Phone # _____________________________________

Who may we discuss results/billing questions: _______________________ Phone #_______________

Who may we contact in case of an emergency? _______________________ Phone #_______________

**Who is your Primary Care Physician? ____

Primary Ins. ____ Insurance ID# ________________

Name of Policy Holder ____________________________ Policy holders date of birth_____________

Secondary Ins.__________________ _______________________ Insurance ID# _________________

**Who is financially responsible for this visit? _____________________ Date of Birth: ___________

Relation to Patient:________________ Phone # _________________ Social Sec. #_________________

I authorize Audiology of Tulsa, PLLC to release information requested with regard to processing my claims.

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 Audiology of Tulsa, PLLC of any changes in my health status or in the above information.

Signature ____ Date ____________________

Parent Signature if Minor ____________________________________ Date ____________________