TWIN RIVERS HEARING HEALTH, INC.
Dr. Mary Kay Uchmanowicz, CCC-A
151 Douglas Pike. Smithfield, RI 02917
(401) 340 -0456

***Who referred you to this office?**

_____

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (Home) (____) _____ (Work) (____) _____

Cell phone #: (____) _____ E-mail address: _____

***Do you wish to receive educational info, specials, events? ☐ Yes ☐ NO**

How do you wish to be contacted: ☐ telephone (cell or home) ☐ text ☐ e-mail

Sex: ☐ Male ☐ Female Date of Birth: __ __/__ __/__ __ SS#: __ __ __/__ __/__ __ __ __

***If a patient is a minor (under eighteen) – Please fill out the following information:**

Legal Guardian or Parent's Name: _____ Relation: _____

INSURANCE INFORMATION

Primary Insurance: ☐ Blue Cross/Blue Shield ☐ United Healthcare ☐ Medicare ☐ Private ☐ Other

Subscriber's Name: _____ Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Name: _____ Policy #: _____

Address: _____

Secondary Insurance: ☐ Plan 65 ☐ Other Co-payment: $_____

Insurance Name: _____ Policy #: _____

Address: _____

EMPLOYER INFORMATION

Worker's Compensation Claim: ☐ No ☐ Yes

Employer Name: _____ Telephone #: (____) _____

Address: _____ Contact Person: _____

PRIMARY CARE PHYSICIAN

Name: _____ Telephone #: (____) _____

Address: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Address: _____ Telephone #: (____) _____

ASSIGNMENT OF BENEFITS

I, the undersigned, authorize Dr. Mary Kay Uchmanowicz, CCC-A, the release of any medical information necessary to the process of this forms and authorizes payment of medical benefits to myself or the name of the provider for medical services rendered to the above named patient. I understand that I will be responsible for any non-covered service not included in my policy, deductibles and co-payments or if my insurance denies payment. I understand should collections ensue I will be liable for any and all collection, court and attorney fees. I understand that payment is due at time services are rendered.

PATIENT SIGNATURE: _____ **DATE:** _____