MID SOUTH HEARING AID CENTER

301 Florence Avenue
Statesboro, GA 30458
(912) 489-6422

2066 Watson Blvd • Suite 406
Warner Robins, GA 31093
(478) 599-9992

1905 B North Columbia St.
Milledgeville, GA 31061
(478) 599-9992

3321 Northside Drive
Macon, GA 31201
(478) 599-9992

Patient Information

DATE: _____ DATE OF BIRTH: _____ AGE: _____ RACE: _____ SEX: _____

PATIENT'S LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: ____

MAILING ADDRESS: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ SS#: _____

HOME PHONE: _____ S M W D (IF MARRIED NAME OF SPOUSE): _____

CELL PHONE: _____ E-MAIL ADDRESS: _____

PERSON RESPONSIBLE FOR BILL: _____ RELATIONSHIP: _____

PATIENT'S/PARENT'S EMPLOYER: _____ WORK PHONE: _____

GUARDIAN'S SS#: _____ FAMILY PHYSICIAN: _____

SIGNIFICANT PAST MEDICAL HISTORY: _____

REASON FOR TODAY'S VISIT: _____ REFERRED BY: _____

HAVE YOU EVER SMOKED? ❑ Y ❑ N

NOTIFY IN CASE OF EMERGENCY: _____ PHONE: _____

MEDICAL CONTRACT AND RELEASE OF INFORMATION FOR MID SOUTH HEARING AID CENTER, I/We hereby grant you, Justin Castleberry, HIS and/or Mid South Hearing Aid Center/your agents the rights to confirm and verify all information given you for the purpose of treatment/billing. I/We are obligated to pay this account in accordance with all regular rate and terms of these offices. I authorize the release of any medical information necessary to process this claim. I authorize payment of insurance benefits directly Justin Castleberry, HIS/ Mid South Hearing Aid Center for services rendered. If this account should be turned over to a collection agency/attorney for nonpayment, I/We assume responsibility for full cost of all collection/legal fees. I understand all delinquent accounts will be assessed at 1.5% interest monthly and 18% annually. I authorize the release of any credit record necessary to process and collect this claim. I certify all information given is correct. I hereby authorize the release and sharing of medical information by and between Justin Castleberry, HIS/ Mid South Hearing Aid Center for the purpose of medical treatment or obtaining a hearing instrument.

_____

PATIENT/ PARENT OR GUARDIAN SIGNATURE

METHOD OF PAYMENT: ❑ CASH ❑ CHECK ❑ CREDIT CARD
❑ MEDICAID ❑ MEDICARE ❑ INSURANCE

PLEASE GIVE INSURANCE CARD(S) TO THE RECEPTIONIST FOR COPY.