

**AUDIOLOGY AND HEARING AID CENTER**

Cynthia Olsen, AuD, CCC-A  
Doctor of Audiology  
1740 N. Milwaukee  
Boise, ID 83704  
208-658-0238

**Patient Information**

Date: \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ F  M

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status \_\_\_\_\_

Work Phone \_\_\_\_\_ E-Mail address \_\_\_\_\_

Cell Phone \_\_\_\_\_ Patient's Employer \_\_\_\_\_

Years w/ Firm \_\_\_\_\_ Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

Spouse Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

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IF Minor

Father's Name \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Father's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Father's DOB \_\_\_\_\_ Mother's DOB \_\_\_\_\_

Mother's Name \_\_\_\_\_ Address \_\_\_\_\_ City, State \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

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Family Physician \_\_\_\_\_ Referred By \_\_\_\_\_

Whom May We Contact in Case of Emergency? (Relationship) \_\_\_\_\_ Phone \_\_\_\_\_

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**Primary Insurance Company Name** \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Subscriber (circle one) **SELF SPOUSE CHILD**

Insured's Phone \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Group No. \_\_\_\_\_ ID No. \_\_\_\_\_

**Secondary Insurance Company Name** \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relationship to Subscriber (circle one) **SELF CHILD SPOUSE**

Insured's Phone \_\_\_\_\_ Insured's Date Of Birth \_\_\_\_\_

Insured's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Group No. \_\_\_\_\_ ID No. \_\_\_\_\_

Is your visit a result of an accident? **Yes**  **No**  Date of Injury \_\_\_\_\_

Is this a Worker's Compensation claim? **Yes**  **No**  Claim Number \_\_\_\_\_

I hereby authorize Cynthia Olsen, AuD, CCC-A, of Audiology & Hearing Aid Center to furnish the patient's insurance company any medical information to obtain benefits. I hereby authorize payment of medical payments to Cynthia Olsen, AuD, CCC-A, of Audiology & Hearing Aid Center for medical services and supplies. I understand that any money received over and above my indebtedness will be returned to me, my insurance company or my employer. I also take responsibility for payment of charges, regardless of payment or denial of payment from my insurance carrier.

I further authorize the Audiology & Hearing Aid Center to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in their files, and authorize the insurance company to accept the photocopy.

I release Cynthia Olsen, AuD, CCC-A, Doctor of Audiology & Hearing Aid Center from all legal responsibility or liability that may arise from this authorization.

This authorization shall continue and be in force and effect until revoked in writing by me.

X \_\_\_\_\_  
SIGNATURE DATE

**MEDICARE PATIENTS SIGN BELOW:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cynthia Olsen, AuD, CCC-A, Audiology and Hearing Aid Center for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to Cynthia Olsen, Doctor of Audiology and her agents any information needed to determine these benefits or the benefits for related service.

X \_\_\_\_\_  
SIGNATURE DATE