Nordstar Audiology II
Compassionate About Your Hearing
www.nordstaraudiology.com
614-834-4364
Fax: 614-834-4368
417 Hill Road North - Pickerington, OH 43147

Please Print Clearly, in blue or black INK

PATIENT INFORMATION

First Name ____________________ Middle Initial _______ Last Name ________________________________
Address (Street) ____
City ______________________________________ ST: _________________ Zip: _______________
Home Phone: _________________ Work Phone: : __________________ Cell: : ________________
Birth Date _______________ Age: ________ Male _____ Female ______
Social Security #__________________ Patient's Occupation: _________
Employer _______________________________Is Patient a full-time student? Yes _____ No _____
Marital Status: Married____ Divorced___ Single____ Separated____ Widowed____
Spouse's Name ___________________ Parent's Name(s) (if pt. is under 18) _____________________________
Referred by: ____
Primary Physician: __________________________________ Phone #________________________________
ENT Physician: _____________________________________ Phone #_______________________________
Emergency Contact: __________________________________ Phone #_________________________________
Email: ____
How did you hear about NORDSTAR Audiology? (Please check one):
_____Referred by Physician _____Referred by Friend _____Radio Ad (name)
_____Newspaper Ad (name) _____School _____Yellow Pages _____Online _____Other

Insurance Information (Please submit Copies)

This area must be completed carefully and entirely for proper submission of your insurance claim. Failure to do so could result in non-payment of claims.

Primary Insurance: ____
Address: ____
Phone#: _____________________ Group ID#: ________________Insurance ID#: _________________
Primary Cardholder _____________________ Birthdate____________Relationship______________________
Primary Cardholder’s employer: _____________________ Social Security #: ______________________
Address of Cardholder if Different from Patient: ____

Secondary Insurance: ____
Address: ____
Phone #: _______________________ Group#: _____________________ ID# _____________________
Primaryardholder: ___________________Birthdate:_____________ Relationship: __________________
Primary Cardholder’s employer:_______________________ Social Security #: ______________________
Address of Cardholder if Different from Patient: ____

SIGNATURE AUTHORIZATION

NORDSTAR Audiology II is a privately owned company and all scheduling and billing will be conducted through the corporation. I authorize direct payment of any medical benefits for services performed at NORDSTAR Audiology II, be sent directly to the office. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. NORDSTAR Audiology II will be happy to assist me with filing insurance, but I understand it is my responsibility to know the rules and regulations of my specific plan, as well as what coverage is included on my plan. It is also my responsibility to contact my insurance carrier to determine if NORDSTAR Audiology II is in my specific network.
I authorize NORDSTAR Audiology II to release any information relating to the service obtained here and those services related to my treatment to other professionals and insurers as may become necessary.
I understand that it is my responsibility to notify NORDSTAR Audiology II if I am unable to keep my scheduled appointment. Failure to give appropriate notice of cancellation may result in a “no show” fee of $30 for which I will assume responsibility. I also permit a copy of this authorization to be used in place of the original. I have read and agree to the above Signature Authorization section and comprehend that it will remain in effect until revoked by me in writing.

Signature: ____Date: ______________________________