The Kaplan Hearing Center

8818 Centre Park Drive, Suite 107
Columbia, MD 21045
(410) 740-4885

Patient Intake

Patient Information

Name _____
First Initial Last

Address _____City_____State_____Zipcode_____

Home Phone _____Work Phone_____Cell Phone_____

Email _____ Social Security #_____

Birth Date _____ Sex M F (circle) Marital Status M S D W (circle)

Employment Status FT PT None (circle) Student Status FT PT None (circle)

Primary Physician _____

Primary Insurance Information (if patient is the insured, enter 'Same' for name and address)

Subscriber's Name _____
First Initial Last

Address _____City_____State_____Zipcode_____

Home Phone _____Work Phone_____Cell Phone_____

Patient's Relation to Subscriber Self Spouse Child Other (circle) Subscriber's Birth Date_____ Subscriber's Sex M F (circle)

Subscriber's Employment Status FT PT None (circle) Subscriber's Employer_____

Insurance Company Name_____

Subscriber's ID Number _____Group Number_____

Other Insurance Information (if patient is the insured, enter 'Same' for name and address)

Subscriber's Name _____
First Initial Last

Address _____City_____State_____Zipcode_____

Home Phone _____Work Phone_____Cell Phone_____

Patient's Relation to Subscriber Self Spouse Child Other (circle) Subscriber's Birth Date_____ Subscriber's Sex M F (circle)

Subscriber's Employment Status FT PT None (circle) Subscriber's Employer_____

Insurance Company Name_____

Subscriber's ID Number _____Group Number_____

CONTACT PERSON / POA NAME_____PHONE_____

I authorize any holder of medical or other information about me to release any information needed to process this or other claims. I permit a copy of this authorization to be used in place of the original and request payment of medial insurance benefits either to myself or to the party who accepts assignment.

Signature _____**Date**_____