Colorado Tinnitus
and Hearing Center, Inc.
Connecting People With The Sounds of Life

Colorado Tinnitus & Hearing Center, Inc.
3601 South Clarkson Street, #220
Englewood, Colorado 80113
PH: 303.534.0163

New Patient Information

Last Name:_____ First Name:_____ Middle Name:_____

Preferred Name:_____ Date of Birth:_____ Sex:_____

Address:_____ City: _____ State: _____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Current Occupation:_____ Employed by:_____

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

Spouse's Name: _____ Phone:_____

Whom may we contact in case of an emergency?_____ Phone:_____

Primary Insurance Company:_____ ID #:_____

Name of Policy Holder: _____ Policy Holder's DOB:_____

Secondary Insurance Company: _____ ID #:_____

Who is financially responsible for this bill?_____ Phone:_____

If you are having a hearing test- we will submit the balance for testing to your insurance company for coverage. If they deem you have additional responsibility, you will be billed for the balance of the invoice within 30 days after submission.

- I authorize Colorado Tinnitus and Hearing Center, Inc. to release information requested with regards to processing my insurance claims.
- I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered.
- I will notify Colorado Tinnitus and Hearing Center, Inc. of any changes to my health insurance status or in the above information.
- I have read all the information on this sheet and certify that this information is correct to the best of my knowledge.

Signature of Patient / Guardian:_____ Date:_____

Printed Name: _____