149 Wakelee Avenue, Ansonia, CT 06401

Patient information

First name	
Last name	
Street	
City, state, zip	
Home phone	
Cell phone	
Work phone	
Email	
Date of Birth	
Primary physician	
Insurance name	
Insured's name	
ID number	
Group number	
Insurance name	
Insured's name	
ID number	
Group number	

I hereby authorize THE HEARING CENTER, LLC to furnish information to insurance carriers concerning my evaluation and treatment, and hereby assign to THE HEARING CENTER, LLC all payments for audiological/hearing aid services rendered to myself or my dependents for which I have not paid. I understand that I am responsible for any amount not covered by insurance

Signature: ________________________________ Date: _______________________