Clarity Audiology & Hearing Solutions, LLC

3290 North Ridge Road, Suite 125
Ellicott City, MD 21043
Phone: #410.696.2890 Fax: #410.696.2886

Date: ____/____/____

Patient Information:

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

Preferred name: _____ Gender: __Male __Female Date of Birth:___ ___/___ ___/___ ___ ___ ___

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip code: ____ ____ ____ ____ ____

Please indicate PRIMARY phone type: CELL / HOME / WORK

Cell Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Home Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Work Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Email: _____

Marital Status: Single / Married / Widowed / Other Employment: Full time/ Part time/ Self/ Unemployed/ Retired

Emergency Contact: _____ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Primary Care Doctor: _____ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Referring Doctor: _____ Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Responsible Party/POA Name: _____ Phone: _____

How did you hear about us? _____

Person Financially Responsible: **(if other than patient)**

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip code: _____ Phone: (___ ___ ___) ___ ___ ___- ___ ___ ___ ___

Primary Insurance Information: **(please enter the policy holder's information)**

Insurance Company: _____ Policy/ID Number: _____

Policy Holders Name: _____ Policy Holders Date of Birth: _____/_____/_____

Relationship to patient: _____ Employer: _____

Secondary Insurance Information: **(please enter the policy holder's information)**

Insurance Company: _____ Policy/ID Number: _____

Policy Holders Name: _____ Policy Holders Date of Birth: _____/_____ /_____

Relationship to patient: _____ Employer: _____