SCH - Patient Intake Form

second chance hearing inc.

Second Chance Hearing Center, Inc.
300 E Esplanade Dr, Ste 370
Oxnard, CA 93036

Phone: (805) 870-4498
Fax: (805) 870-4625

1. Patient First Name: (required)

2. Patient Last Name: (required)

3. Perferred Name:

4. Date of Birth: (required)

5. Age:

6. Marital Status: (required)

- ○ Single
- ○ Married
- ○ Divorced
- ○ Partner
- ○ Widowed
- ○ Legally Separated
- ○ Other

7. Gender: (required)

- ○ Male
- ○ Female
- ○ Not Specified

8. Last 4 digits of Social Security #:

9. Address Line #1: (required)

10. Address Line #2:

11. City: (required)

12. State / Province: (required)

13. Postal Code: (required)

14. Phone #1: (required)

Home ▾ - -

15. Phone #2:

Home ▾ - -

16. Phone #3:

Home ▾ - -

17. Email:

18. Occupation: (required)

19. Name of Emergency Contact: (required)

20. Emergency Contact Relation: (required)

21. Emergency Contact Phone #: (required)

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22. (Under 18) Name of Parent or Guardian:

23. Address of minor (if different from above):

24. Primary Care Physician Name:

25. Primary Care Physician Phone #:

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26. Who can we thank for your referral?

Insurance and Billing Information

1. Are you receiving any care in your home, including nurse/aides, physical/occupational/ speech therapy? (required)

- ○ Yes
- ○ No

Additional Comments:

2. Name of Primary Insurance Company: (required)

3. Name of Policy Holder: (required)

4. Date of Birth of Policy Holder: (required)

5. ID#: (required)

6. Group #: (required)

7. Primary Insurance Provider Phone #: (required)

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8. Name of Secondary Insurance Company:

9. Name of Policy Holder:

10. Date of Birth of Policy Holder:

11. ID#:

12. Group #:

13. Secondary Insurance Provider Phone #:

- -

14. Spouse's Name (if insurance policy holder):

15. Spouse's Date of Birth (if insurance policy holder:

16. Spouse's Address (if different from above and insurance policy holder):

17. Spouse's Employer (if insurance policy holder):

18. Spouse's Work Phone (if insurance policy holder):

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19. I certify that the information given by me on this form is correct. (required)

○ Yes all the information completed on this form is correct.

○ I have additional questions.

Assignment of Insurance Benefits

1. I hereby authorize direct payment to Second Chance Hearing Center, Inc. for services rendered to me or my dependent.

○ Yes, I understand
○ I have additional questions

2. I understand that my insurance company may only cover a portion of the total bill. I understand that I am financially responsible for any remaining amounts which are not covered through my current benefit plan.

○ Yes, I understand
○ I have additional questions

3. Second Chance Hearing Center, Inc. was in contact with my insurance carrier and obtained an estimated coverage of benefits. Second Chance Hearing assumes no responsibility for guaranteeing payment of any charges from my insurance company.

○ Yes, I understand
○ I have additional questions

4. Payment is required at time of service by cash, check or credit card. Payment will be collected for known charges such as co-payments, co-insurances, deductibles, and services which are not covered through my benefit plan.

○ Yes, I understand
○ I have additional questions

5. Should an overpayment take place, a refund check will be mailed within 30 days to the authorized party that is due the overpayment.

○ Yes, I understand
○ I have additional questions

Patient/Guardian Signature (Use mouse cursor to draw signature in the panel below)

[Clear]