



8279 Route 22  
Keystone Plaza, Ste 11  
New Alexandria, PA 15670  
724-668-5091

1225 South Main Street  
Wellington Square, Ste 202A  
Greensburg, PA 15601  
724-205-6907

2010 Route 30 East  
Freedom Dental Center  
Ligonier, PA 15658  
724-205-6907

2545 Mosside Blvd  
Mosside Medical Center  
Monroeville, PA 15146  
412-229-8841

**Patient Information**-please print

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ M F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Reason for today's visit: \_\_\_\_\_

***Person Responsible for Account***

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

**How did you hear about us?**  Newspaper  Website  Mail  Insurance Carrier  
 Health Fair  Referred by Friend/Family  Referred by Physician

**Do you own a smart phone?**  Yes  No  Android  iPhone

**Assignment and Release for Insurance**

We will happily bill your primary insurance carrier. In order to do so, you must read and sign the following release of information:

I hereby authorize D'Aurora Hearing and Audiology to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to D'Aurora Hearing and Audiology and am financially responsible for any unpaid balance.

Signature of Patient or Guardian: X \_\_\_\_\_

Date: \_\_\_\_\_