VICTORIA HEARING CENTER
117 Medical Dr Ste 2 Victoria, Texas 77904 (361) 573-4832

PATIENT NAME: _____ Appt Date: _____
FIRST MI LAST

ADDRESS _____
PO BOX/STREET CITY STATE ZIP

HOME TEL# _____ CELL #: _____

PREFERRED CONTACT METHOD: _____

EMAIL ADDRESS _____

BIRTHDATE: _____ AGE: _____ SEX _____ SOCIAL SECURITY# _____

REFERRING PHYSICIAN: _____ DOCTOR: _____

EMPLOYER: _____ ADDRESS: _____
PO BOX/STREET

CITY/STATE/ZIP _____ WORK TEL# _____

**Complete this section if patient is a minor.** *(ADULT PRESENTING MINOR FOR TREATMENT WILL BE RESPONSIBLE PARTY ON ACCT.)*

PARENT/LEGAL GUARDIAN: _____ BIRTHDATE: _____ RELATIONSHIP: _____
M/D/YR

MAILING ADDRESS: _____
PO BOX/STREET CITY STATE ZIP

EMPLOYER: _____ ADDRESS _____
PO BOX /STREET

CITY: _____ STATE/ZIP _____ HOME TEL# _____

WORK TEL# _____

**Complete this section for the cardholder of the insurance.**

POLICYHOLDER NAME: _____ SS# _____

INSURANCE: _____ DOB: _____
M/D/YR

POLICYHOLDER NAME: _____ SS# _____

INSURANCE: _____ DOB: _____
M/D/YR

EMERGENCY CONTACT/RELATIONSHIP TO PATIENT: _____

HOME# _____ CELL# _____ Work# _____

**CMS, a federal agency within the U.S. Health & Human Services, is requesting that medical providers obtain this information.**
**PLEASE HELP US BY FILLING THIS OUT. THANK YOU.**

Ethnicity: ____Decline to State _____Hispanic or Latino _____Not Hispanic or Latino

Race: ____Decline to State ____American Indian or Alaska Native ____Asian ____Black or African American ____White
____Native Hawaiian or Other Pacific Islander ____Some Other Race

Preferred Language: ____English ____Spanish ____Other, please indicate_____