Eden Medical Plaza: 20126 Stanton Ave. #205 Castro Valley, CA 94546
Plaza Real: 39210 State St. #116 Fremont, CA 94538

Patient Name:_____Date of Birth_____
Address: _____City:_____
State: _____ZIP:_____Home Phone_____Cell Phone_____
Email_____Social Security Number_____
Sex__M__F Marital Status__M__S__D__W
Employer Name:_____Phone Number_____
Employer Address:_____

Who referred you to The Hearing Center? _____

Primary Care Doctor_____

Spouse/Parent Information:
Name:_____Date of Birth_____
Employer Name: _____
Employer Address:_____Phone Number_____

Emergency Contact:
Name: _____Relationship:_____
Phone Number_____

Person responsible for payment_____
Our office is NOT a provider for all insurance companies. We do ask for payment at the time of service and will bill covered services to your insurance company as a courtesy.

Authorization: I hereby authorize The Hearing Center of Castro Valley to furnish information to insurance carriers and irrevocably assign to The Hearing Center of Castro Valley all payments for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance carrier.

Responsible Party
Signature_____Date_____

Subscriber Name (If other than patient)_____Date of Birth_____