Lyric Audiology, PLLC

371 State Route 17M, Suite 7
Monroe, NY 10950
(845) 395-0300

Patient Intake Form

Date: _____

NAME: □Mr. □Mrs. □Miss □Ms. □Dr. _____

ADDRESS: _____

City: _____St. _____Zip: _____

PHONE: (home)_____ (work)_____(cell)_____

D.O.B.:_____ Social Security #: _____

□Single □Married □Widowed/Divorced □Other Name of Spouse/SO: _____

Employment Status: □Employed □ Retired □Student □Other

If patient is a minor

Name of Parent or Legal Guardian:_____

Address:_____

Phone: _____

Primary Insurance: (copy of card required)_____

Name of Policy Holder _____Relationship to Patient:_____

ID#:_____ Group #: _____Phone #_____

Secondary Insurance: _____

Name of Policy Holder _____Relationship to Patient:_____

ID#:_____ Group #: _____Phone #_____

Reason for Visit: _____

Referring Physician: _____

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Emergency Contact: Name:_____

Relationship: _____

Address: _____

Phone: _____