Cadence Hearing Services, LLC
207 Corporate Drive East
Langhorne PA 19047
(215) 860-3154

Name____________________________________ Date of Birth____________________

Address____

Email____

Phone number____________________ Cell Phone ____________________________

How did you hear about us? ____

Mother's name______________ Address______________________ Phone__________

Father's name_______________ Address______________________ Phone_________

Type of insurance_______________________ Policy number______________________

Date of birth of insurance card holder____________________________

Name of Primary Physician_____________________ Address_____________________

City________________________ State_________ Zip__________ Phone____________

Child's current school___________________________ Address __________________

Phone number ___________________________ Current grade_____________________

I understand that I am financially responsible for payment of services rendered by Cadence Hearing Services, LLC. I request that payment for authorized insurance benefits and or Medicare benefits be made to me or on my behalf to this doctor. I authorize any holder of medical information to release to the appropriate agents any information needed to determine these benefits payable for related services. A copy of my signature is as good as the original. My practice is committed to securing the privacy of your health information. You are not required to read the practice's Notice of Privacy Practice, but it is available to you. However, we would like your acknowledgement that you have been notified that the practice has such a Privacy Practice Notice.

Signature_______________________________________ Date__________________