

WELCOME TO
Richard Polhill Professional Hearing Solutions

Consumer Information:

Date: _____

Name: _____

Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Day Phone: _____ **Other Phone:** _____ **Mobile Phone:** _____

Email: _____ **Gender:** M F **Date of Birth:** _____

Would you like to receive discount offers via Email? _____ **Yes** _____ **No**

Marital Status: ___ **Single** ___ **Married** ___ **Other** **Companion's Name:** _____

Employment Status: ___ **Retired** ___ **Employed** ___ **Student: FT/PT** ___ **Other**

Family Doctor: _____ **Phone #:** _____

Referring Physician: _____ **Phone #:** _____

Referred by? Newspaper ___ Direct mail ___ TV ___ Website ___ Friend ___

Would you like your results sent to your family doctor? _____ **Yes** _____ **No**

Do you have insurance that offers a hearing health benefit?

 ___ **Humana** ___ **BC/BS** ___ **Florida Health Care** ___ **Aetna** ___ **AARP** ___ **United Health Care**

Insurance Information: please provide Insurance card(s) with this completed form:

Policy Holder's Name: _____ **Policy Holder's Date of Birth:** _____

Address: _____ **City:** _____ **Zip:** _____

Day Phone: _____ **Mobile Phone:** _____ **Social Security** _____

Date of Birth: _____ **Insurance Company:** _____

Insured's ID#: _____ **Insured's Policy Group:** _____

Policy Holders Relationship: ___ **self** ___ **spouse** ___ **other**

Insurance Plan Name / Program: _____

Policy Holder's Employer Name _____ **Phone:** _____