

Sarah Proulx, Au.D., CCC-A  
Megan Blanchette, Au.D., CCC-A  
Nancy C McMahon, Au.D., CCC-A

**Center for Better Hearing, LLC**  
160 West Street, Building 1, Suite B  
Cromwell, CT 06416 (860) 632-5003  
contact@centerforbetterhearing.com

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M / S / W / D

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

( ) Home Phone: \_\_\_\_\_

( ) Cell Phone: \_\_\_\_\_

( ) Employer Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

( ) Email Address: \_\_\_\_\_

**\*\*Please indicate preferred method of contact. We use both text and email for appointment reminders\*\***

Who referred you to our office? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

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**Assignment of Benefits – Release of Information**

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance and any other health plans to CFBH, LLC. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information that is necessary to secure payment. Our office uses electronic signatures on required documents. I, agree and understand, that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date