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

Financing with 0% interest is available for up to 12 months.

Would you like to know more about this financing? _____Yes ____No

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: _____