Patient Information Form

Chart #_____ Date _____

Patient Name _____ DOB ____/____/____
First MI Last mm dd yyyy

Name of Responsible Party (If under 18) _____ DOB ____/____/____
First MI Last mm dd yyyy

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Patient's SSN _____ Sex ○ M ○ F

Email Address _____

Mailing Address _____
Street City State ZIP

Secondary Address _____
Street City State ZIP

Preferred Method of Contact ○ Home phone ○ Work phone ○ Cell phone ○ Email ○ Mail

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status ○ Married ○ Single

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

○ Mail ○ Newspaper ad ○ Promotional call ○ Radio ○ Insurance

○ Yellow pages ○ Sponsored event ○ Health/senior fair ○ Online ○ Employer

○ Social media ○ Referred by friend _____

○ Referred by physician _____

○ Other _____

Reason for Appointment _____

_____

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Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Please read carefully and sign below.

- I give permission to my practice to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize my practice to use and release my contact information for marketing related to health care products or services.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.
- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original) Date

Signature of Parent or Guardian Date