Patient Information

Date

M ❏ F ❏

Last Name | First | Middle Initial | Gender

Address | City | State | Zip

Home Phone | Cell | email

Date of Birth | Age

Spouse/Partner's Name or Alternate Contact | Relationship Other Than Spouse

Phone Number | Cell Phone | email

Y ❏ N ❏

Were You Referred to Us? | If Yes, Who Do We Thank? If No, How Did You Find Us?

Your Physician | Phone

Reason for Today's Appointment

HIPPA Privacy Acknowledgement

I have received the notice of Privacy Practices, and I have been provided an opportunity to review it. Y ❏ N ❏

May we share your medical information with your doctor? Y ❏ N ❏

May we leave a message on your phone, email or answering machine regarding your hearing care? Y ❏ N ❏

May we discuss your hearing healthcare with a family member, spouse/partner? Y ❏ N ❏

Patient's Signature | Patient's Name (Please Print) | Date

I authorize release of information to all insurance companies, and I understand that I am ultimately responsible for any balance due. I authorize release of medical records and evaluations to the doctors/agencies listed above.

Patient's Signature | Patient's Name (Please Print) | Date