

## **Patient Information**

		Date			
				М	F 🛄
Last Name		First	Middle Initial	Gender	
Address		City	State		Zip
Home Phone	Cell	ema	ail		
Date of Birth	Age	_			
Spouse/Partner's Name or Alterna	te Contact		Relationship Other	Than Spor	use
Phone Number	Cell Phor	ne	email		
Y 🗀 N 🗀					
Were You Referred to Us? If Ye	s, Who Do We Thank? If No, How [	Did You Find Us?			
Your Physician			Phone		
Reason for Today's Appointment					
HIPPA Privacy Acknow	ledgement				
I have received the notice of Privacy Practices, and I have been provided an opportunity to review it.					' 🗀 N 🗀
May we share your medical information with your doctor?					N
May we leave a message or	your phone, email or answe	ering machine regar	ding your hearing ca	re? Y	′ 🗀 N 🗀
May we discuss your hearing	g healthcare with a family m	ember, spouse/parti	ner?	Υ	′ 🗀 N 🗀
Patient's Signature	Patient's	Name (Please Print)	Date		
I authorize release of inform any balance due. I authorize	ation to all insurance compa e release of medical records	nies, and I understar and evaluations to t	nd that I am ultimate he doctors/agencies	ly respor listed al	nsible for pove.
Patient's Signature	Patient's	Name (Please Print)	Date		