

Patient Information Form

Chart # _____ Date _____

Patient Name _____ DOB _____
First MI Last mm dd yyyy

Email Address _____

Primary Phone # _____ Cell Landline Gender: _____

Secondary Phone # _____ Cell Landline Patient's SSN # _____
May be needed for Insurance Processing

Occupation (Current or Prior): _____ Retired?

Local/FL Address _____
Street City State ZIP

Other Address _____
Street City State ZIP

Preferred Method of Contact Primary phone Secondary phone Email Mail

Marital Status Married Single Widowed Divorced Long-term commitment

Companion Name _____ Relation to Patient: _____

Emergency Contact _____ Phone # _____

Primary Care Physician _____ Phone & Fax # _____

How did you hear about us?

- Mail Newspaper ad Audiologist Audigy Insurance
 HA Company Vocational Rehab Walk-in Website Employer
 Referred by friend _____
 Referred by physician _____
 Other _____

Reason for Appointment _____

If patient is under the age of 18, please indicate responsible party.

Name of Responsible Party _____
First MI Last

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We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. What can we do to make your next visit more comfortable?

Insurance Information

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

Primary Insurance: _____ Subscriber ID #: _____

Group # _____ Plan # _____

Secondary Insurance: _____ Subscriber ID #: _____

Group # _____ Plan # _____

Please read carefully and sign below.

- I give permission to my AudigyCertified™ 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 healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- 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