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

SnowBird 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, responsible party must complete remainder of this section.

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