Patient Information Form

Patient Name ______________________________ Date ________
First MI Last

Preferred Name ______________ Date of Birth ___/___/_____ Age ______ Gender ◯ Female ◯ Male

Home Phone # ______________________ Cell Phone # ______________________

◯ Please check if we can leave a detailed message.

Work Phone # ______________________ Email ______________________

Mailing Address ____
Street City State Zip Code

How did you hear about us?

◯ Walk-in ◯ DVR ◯ Employer ◯ HLA ◯ Insurance ◯ Mail ◯ Newspaper Ad ◯ Senior Center ◯ Yellow Pages

◯ Lions Club ◯ Assisted Living Facility ______________ ◯ Online ______________ (website/search engine)

◯ Event ______________ ◯ Family/Friend/Patient ______________________

◯ Physician/Facility ______________ ◯ Other ______________________

Employment Status: ◯ Retired ◯ Full-time ◯ Part-time ◯ Unemployed ◯ Student

Occupation/Employer (if **RETIRED**): ______________________________

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Long-Term Commitment

Spouse/Partner Name ______________________ Emergency Contact______________________

Phone # ______________________ Relation to Patient ______________________

Primary Care Physician and/or Facility ______________________________

Insurance Information: Please let our front office staff know if you have insurance so that we can make a copy for our records.

Assignment and Release: Please read below carefully

I, the Patient or Guardian, certify that the information on this form is true to the best of my knowledge. I authorize The Hearing Center to release any information necessary to process an insurance claim on my behalf. I also authorize my insurance benefits to be paid directly to The Hearing Center and I understand that I am financially responsible for all charges whether or not paid by my insurance. I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I have read and understand the above information.

Patient Signature ______________________________ Date ______________

Legal Guardian Signature ______________________________