

Patient Information Form



Date _____ Verified _____ Date _____
Verified _____ Date _____
Verified _____ Date _____

Patient Name _____ DOB _____ / _____ / _____
First MI Last mm dd yyyy

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Can we leave a message (Check all that apply): Home Cell Work

Email Address _____

Mailing Address _____
Street City State ZIP

Age _____ Sex M F Occupation/Prior Occupation (if retired) _____

With whom do we have permission to discuss your results and treatment? Please list (e.g., spouse, children, parents): _____

Marital Status Married Single Widowed Divorced Long-term commitment

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

May we send a report to your primary care physician? Yes No

How did you hear about us?

Mail Newspaper ad Promotional call Radio Insurance

Yellow pages Sponsored event Health/Senior Fair Website Employer

Referred by friend _____ Referred by physician _____

Other _____

Reason for Appointment _____

Turn over...

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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. To provide you with the highest level of service, please rate your experience in the following areas:

Location and accessibility	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Adequate parking	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Convenience of appointment times	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Friendly greeting	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor
Clean and welcoming environment	<input type="radio"/> Excellent	<input type="radio"/> Average	<input type="radio"/> Poor

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.

Please read carefully and sign below.

- I hereby give my permission to Hearing Rehab Center to use and disclose verbal and written protected health information (PHI) about me to carry out treatment, payment, and health care operations. The Notice of Privacy Practices provided by Hearing Rehab Center describes such uses and disclosures more completely and can be requested at any time.
- With this consent, Hearing Rehab Center may call, email, or mail to my home (or other alternative location) any items that assist the practice in carrying out health care operations, such as appointment reminder cards and clinical communication. I understand that this communication authorization is in effect until a revocation is received by Hearing Rehab Center.
- I acknowledge that I have the right to review the Notice of Privacy Practices at length under the Health Insurance Portability & Accountability Act (HIPAA) prior to signing this consent.
- 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 Hearing Rehab Center 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