Patient Information Form

Chart # ______________ Date ______________

Patient Name ____ DOB ____/____/________
First MI Last mm dd yyyy

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party ____
First MI Last

Home Phone # ______________ Cell Phone # ______________ ○ iPhone ○ Android ○ Other

Work Phone # ______________ Patient's SSN ______________ Sex ○ M ○ F

Email Address ____

Mailing Address ____
Street City State ZIP

Secondary Address ____
Street City State ZIP

Preferred Method of Contact ○ Home phone ○ Work phone ○ Cell phone ○ Email ○ Mail

Age ______________ Occupation ______________
(If retired, prior occupation)

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Spouse Name ____

Emergency Contact ______________ Phone # ______________

Relation to Patient ____

Primary Care Physician ______________ Phone # ______________

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 ____

____

Patient Information Form

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 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.
- Is it okay to leave a detailed message on your answering machine? Yes/No
- Is it okay to release information to anyone other than you? Yes/No

  If answer is YES, please list each person:

  Name:____________________ Relationship____________________

  Name:____________________ Relationship____________________

  (Reminder, we will not release information to anyone not listed)

- I authorize my AudigyCertified practice to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.
- 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