Welcome to our office!

Patient Information

Date____________________

Patient Name - Last _________________________________ First ________________________ Middle ____________________

Address - Street____ City__________________ State ______ Zip ___________

Home phone ________________________ Cell Phone ______________________ Social Security # ______________________

M ___ F ___ Age______ Birthdate_____________________ Single___ Married___ Widowed___ Divorced___ Other___

Spouse's Name ________________________ Email address___________________________ DL# ________________________

Employer: name, address, city, st ____

Work phone ______________________ Full time__ Part time__ Retired__Not employed__ Self-employed__ Active military__

Emergency contact (nearest relative not living with you): Name____

Address__________________________________ City/St _________________ Phone_______________ Relationship ________

Name of primary care physician ____ Phone ___________________________

How did you hear about our office?

Internet___ Newspaper___ Yellow Pages___ Mail___ Insurance___ Physician___ Friend-name______________ Other____

May we have permission to:

Discuss your hearing healthcare with your spouse/other family member? Yes___ No___

Send a reminder card notifying you of your hearing aid warranty expiration? Yes___ No___

Send an annual screening reminder, information about new hearing aid technology, etc.? Yes___ No___

Telephone/leave messages regarding hearing related issues? Yes___ No___

Responsible Party Information (if different from above)

Name –Last _______________________________________ First__________________________ Middle____________________

Home Address____ City ___________________ State ______ Zip __________

Birthdate____________________________ Phone____________________________ Cell Phone__________________________

Relationship to patient _______________________ Email Address____

Employer-name & address ____

Phone_____________________ Full time___ Part time___ Retired___Not employed___ Self-employed___ Active military___

Insurance Information

Primary

Name of Insured_____________________________________ Date of Birth _________________ Phone_________________

Address____ City __________________ State ______ Zip __________

Phone __________________________________ Relationship to patient ____

Insurance Company _______________________ Member ID #________________________________ Group #___________

Secondary

Name of Insured_____________________________________ Date of Birth _________________ Phone_________________

Address____ City __________________ State ______ Zip __________

Phone __________________________________ Relationship to patient ____

Insurance Company _______________________ Member ID #________________________________ Group #___________

The undersigned certifies that the information in this document is true and correct.

____ ____

Patient or Patient's Representative | Relationship, if other than patient

____ ____

Witness | Reason patient is unable to sign

Rev 2- 05/28/14