Patient Information Form

HEARING CENTER OF PLAINVIEW

Patient Name _____ **DOB** ____/____/____
SALUTATION FIRST MI LAST MM DD YYYY

Reason for Appointment _____

_____

Have you noticed any buzzing or ringing in your ears? ○ Yes ○ No

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

Name of Responsible Party _____ **DOB** ____/____/____
FIRST MI LAST MM DD YYYY

Home Phone _____ **Other Phone** _____

Cell Phone _____ Sex / Gender ○ M ○ F ○ Transgender ○ Intersex

Email Address _____

Mailing Address _____
STREET CITY STATE ZIP

Secondary Address _____
STREET CITY STATE ZIP

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

Age _____ Occupation _____
(IF RETIRED, PRIOR OCCUPATION)

Relationship Status ○ **Married** ○ **Single** ○ **Widowed** ○ **Separated** ○ **Long-term Commitment**

Spouse/Partner Name _____

Emergency Contact _____ Phone _____

Relation to Patient _____

Primary Care Physician _____ Phone _____

Primary Insurance _____ **Policy ID #** _____

Name of Policy Holder _____ Group ID # _____

Relationship of Patient to Policy Holder _____ Policy Holder's Date of Birth _____

Policy Holder's Employer _____ Employer's Phone _____

Secondary Insurance _____ **Policy ID #** _____

Name of Policy Holder _____ Group ID # _____

Relationship of Patient to Policy Holder _____ Policy Holder's Date of Birth _____

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Are you experiencing any of the following?

- O Heart disease
- O History of cancer treatment
- O Alzheimer's disease
- O Recent hospitalizations
- O Taking blood thinners
- O Tinnitus
- O Hypertension
- O Osteoporosis
- O Dementia
- O Falls
- O Thyroid problems
- O Dizziness
- O Diabetes
- O Cognitive decline

How did you hear about us?

- O Online _____
- O Magazine _____
- O Radio _____
- O Direct Mail _____
- O Email Newsletter _____
- O Newspaper _____
- O Yellow Pages _____
- O Television _____
- O Newsletter _____
- O Walk-In _____
- O Physician _____
- O Referral
  - o Patient _____ o Friend _____
  - o Family _____ o Employee _____
- O Existing Patient _____
- O Other _____

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 health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- 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 understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- 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