Hearing and Speech Center

PATIENT INFORMATION FORM

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 _____ DOB ____/____/____
First MI Last mm dd yyyy

Home Phone #_____ Cell Phone # _____

Work Phone # _____Gender_____

Email Address _____

Mailing Address _____
Street City State ZIP

Occupation (past and/or present) _____

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

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

Partner Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

○ Mail ○ Newspaper ad ○ Insurance ○ Radio ○ Television
○ Yellow pages ○ Sponsored event ○ Health/senior fair ○ Online ○ Employer
○ Referred by friend _____
○ Referred by physician _____
○ Other _____

Reason for Appointment _____

_____

_____

Hearing and Speech Center

PATIENT INFORMATION FORM

Please read carefully and sign below.

- I give permission to Hearing and Speech Center to release information, verbal and written (contained in my medical record and other related information), to my insurance company, related healthcare providers, assignees and/or beneficiaries, or other individuals as specified:
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- Information without patient identifiers may be used for quality purposes.
- 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 and Speech 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