HEARING HEALTH CARE, INC.

Patient Information Form

Today's Date: ________________ **Please Print & Complete All Lines**

Patient Name____ DOB_____/_____/_______

First MI Last MM DD YYYY

Marital Status:☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other Sex: ☐ Male ☐ Female

Work Status: ☐ Student ☐ Part-Time ☐ Full Time ☐ Retired ☐ N/A SS#_____________________

Mailing Address ____

Street City State Zip Code

Home Phone# (______)_____________________ Cell Phone# (______)______________________

Work Phone# (______)_______________________ E-Mail __________________________________

Please * preferred phone # above to reach you.

May we leave a message for appointment reminders? (Circle one) Yes No

May we leave a message regarding your account balance? (Circle one) Yes No

May we leave a message regarding your care? (Circle one) Yes No

Whom else may we leave a message with or speak to about your care? ____________________________

May we contact you via text? (Circle one) Yes No If yes, which phone#: _____________________

May we contact you via E-mail? (Circle one) Yes No If yes, what email address:________________

May we contact you regarding our marketing offers? (Circle one) Yes No

Either directly (from our office) or from a third party / vendor.

Name of Responsible Party____

(If different than patient) First MI Last

Mailing Address ____

(If different than patient) Street City State Zip Code

Insurance Information –

Please give all insurance cards & a photo ID to staff so we can make a copy for our records.

Primary Ins_______________________________ Policy Holder Name ___________________________

Policy Holder DOB_____/_____/_______ Relation to Patient ☐Self ☐Spouse ☐Mother ☐Father ☐Other

MM DD YYYY

Secondary Ins_____________________________ Policy Holder Name ___________________________

Policy Holder DOB_____/_____/_______ Relation to Patient ☐Self ☐Spouse ☐Mother ☐Father ☐Other

MM DD YYYY

Please Complete Other Side

Emergency Contact_________________________________ **Phone#(_____)**________________________
Relationship to Patient__________________________________

Primary Care Physician_________________________________ **Phone#(____)**_____________________

How did you hear about Hearing Health Care?
☐ **Mail** ☐ **TV** ☐ **Radio** ☐ **Yellow Pages** ☐ **Website** ☐ **Sponsored Event** ☐ **Health/Senior Fair** ☐ **Employer**
☐ **Insurance** _________________ ☐ **Newspaper Ad** ______________ ☐ **Other** _________________
Referred by ☐ **Family/Friend**______________________ ☐ **Physician**________________________

Please Read Carefully and Sign Below:

- I hereby give permission to Hearing Health Care to release any information - verbal and/or written (contained in my medical record and other related information), to my insurance company, healthcare provider(s), care giver, school, assignees and/or beneficiaries or other related persons as it pertains to my hearing care needs/services.
- I acknowledge that I have received, reviewed and accepted the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- I request that the payment of my insurance benefits be made payable to Hearing Health Care for all services rendered and authorize the release of information required to determine these benefits.
- 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. If necessary to place my account with a collection agency, I will be required to pay all collection costs and attorney fees to the extent limited by the law.
- 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 hereby give Hearing Health Care permission to treat my concerns.

I have read and understand all the above information.

____ ________________ _____________
Patient Signature or Signature of Parent/Guardian **Relation to Pt** **Date**