

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# \_\_\_\_\_

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

Name of Responsible Party \_\_\_\_\_  
First MI Last

Home Phone# (\_\_\_\_) \_\_\_\_\_ Cell Phone# (\_\_\_\_) \_\_\_\_\_

Work Phone# (\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip

Emergency Contact \_\_\_\_\_ Phone#(\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone#(\_\_\_\_) \_\_\_\_\_

Insurance Information –

Please give all insurance cards 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

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 \_\_\_\_\_

**Help Us Help You:**

We strive to provide a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

|                                  |                                    |                                  |                               |
|----------------------------------|------------------------------------|----------------------------------|-------------------------------|
| Location and accessibility       | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Adequate parking                 | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Convenience of appointment times | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Friendly greeting                | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| Clean & welcoming environment    | <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |

What could we do to make your next visit more comfortable? \_\_\_\_\_

**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 providers, care giver, case manager, attorney, employer, school, assignees and/or beneficiaries and all other related persons.  
\_\_\_\_\_ Initial to refuse permission to release medical records.
- 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.
- 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 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**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature or Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature or Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**