Patient Information Form

Date _____

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 _____
First MI Last

Home Phone #_____ Cell Phone # _____ ○iPhone ○Android ○Other

Work Phone # _____ Patient's SSN _____ Sex ○ M ○ F

Email Address _____

Mailing Address _____
Street City State ZIP

Preferred Method of Contact ○ Phone ○ Email ○ Mail

Age _____ Occupation _____
(If retired, prior occupation)

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

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

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

Reason for Appointment _____

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

Location and accessibility	○ Excellent	○ Average	○ Poor
Adequate parking	○ Excellent	○ Average	○ Poor
Convenience of appointment times	○ Excellent	○ Average	○ Poor
Friendly greeting	○ Excellent	○ Average	○ Poor
Clean and welcoming environment	○ Excellent	○ Average	○ Poor

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 acknowledge that I received a copy of the Neuro-Communication Services, Inc., dba Hearing Innovations Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.
    - This Notice informs me how Neuro-Communication Services, Inc., dba Hearing Innovations will use my health information for the purposes of my treatment and/or payment for my treatment.
    - This Notice explains in more detail how Neuro-Communication Services, Inc., dba Hearing Innovations may use and share my health information for other than treatment, payment, and health care operations.
    - Neuro-Communication Services, Inc., dba Hearing Innovations will also use and share my health information as required/permitted by law.
- I authorize Hearing Innovations 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 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