Patient Information Form

Salutation_____Last Name_____ First Name_____ MI_____

Birth Date _____ Sex _____ Home Phone: _____ Cell:_____

E-mail Address: _____

Mailing Address (Street) _____

City _____ ST. _____ ZIP_____

I **DO NOT** wish to receive marketing and service reminders by (select any/all that apply):
Mail: _____ Phone: _____ Text: _____ E-mail: _____ *(you may change this at any time)*

Emergency Contact Name: _____ Phone Number: _____ Relation: _____

Primary Care Physician: _____

Whom may we thank for referring you to our office? _____

Primary Ins. _____Insurance ID# _____

Name of Policy Holder _____ Policy Holder's DOB_____

Secondary Ins._____ _____ Insurance ID# _____

I authorize to release information requested with regard to processing my claims.

I understand and agree (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify this information is correct to the best of my knowledge. I will notify of any changes in my health status or in the above information.

I hereby acknowledge I have been presented with a copy of Hearing Assessment Center, LLC,'s NOTICE OF PRIVACY PRACTICES.

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(if minor)