Name_____ Sex ☐M ☐F
(First) (M.I.) (Last)

Mailing Address _____
(Street/PO Box) (City) (State) (Zip Code)

Home Phone _____ Work Phone _____ Cell _____

Birth Date _____/_____/_____ Age_____ Primary Care Dr. _____

Email_____

Emergency contact: _____ Relationship:_____

Emergency contact phone number:_____

Person responsible for insurance: _____
(First) (M.I.) (Last)

Relationship to Patient: _____ Birthdate:____/____ /____

Address(if different from patient's)_____
(Street/PO Box) (City) (State) (Zip Code)

Person Responsible Employed by_____ Occupation_____

May we leave a message on your answering machine?	Yes	No
May we contact you at work?	Yes	No
May we leave a message with anyone who answers the phone numbers provided?	Yes	No
May we contact you via e-mail?	Yes	No

Reason for appointment:_____

How did you hear about us?

☐ Referred by Friend/Family_____

☐ Referred by Physician _____

☐ Yellow Pages ☐ Mail ☐ Newspaper ☐ Website ☐ Insurance

☐ Employer ☐ Radio ☐ Other_____

A copy of your insurance card is requested for this space.	A copy of your insurance card is requested for this space.

We believe in, and 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	☐ 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

Please read carefully and sign below

- I give permission to Advanced Hearing Plus to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

  I give my permission to release my information to any of the above:_____
  (Initial)

- I authorize Advanced Hearing Plus to use and release my protected health information, i.e. my contact information, for marketing related to hearing care products or services.

  DO NOT release my information for marketing related to hearing care products or services _____
  (Initial)

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

- I understand and agree that insurance coverage is not a guarantee of payment and, 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 hereby give Advanced Hearing Plus 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