High Country Hearing Centers

Patient Intake Form

First Name _____ **Home Phone** _____

Middle Initial _____ **Cell Phone** _____

Last Name _____ **Work Phone** _____

Date of Birth _____ **Today's Date** _____

Mailing Address _____

Physical Address _____

City _____ **State** _____ **Zip** _____

Email Address _____

Spouse or Emergency Contact _____**Phone Number** _____

Spouse or Emergency Contact able to Receive Medical Information over the Phone **Yes/No**

Primary Care Physician _____

Would you like a copy of your Audiological Exam sent to your Primary Care Physician? **Yes / No**

Who did you bring with you to your Appointment? _____

Who can we thank for referring you to us? Win/Win _____

Circle All that Apply: (Current Patient) (New Patient) (Miner's Benefit) (DVR) (Treatment FI)

(Mailer) (Radio) (Chamber of Commerce) (AD) (Phone Call from Us) (Friend or Family) (Win/Win)

HIPPA Acknowledgement

I acknowledge that I have been offered a copy of the Notice of Privacy Practices and I authorize High Country Hearing Centers LLC, to send copies of my hearing reports to my primary care physician to keep him or her informed of my health. In addition, I authorize High Country Hearing Centers LLC (HCHC) to share my hearing and protected medical information (including demographics, as needed, with doctors, employees, and staff of HCHC, including other offices, divisions, locations, and base of HCHC, for the purposes of providing treatment, evaluations, exam, hearing services and/ or equipment, and to arrange for payment of my healthcare bills.

I am authorizing _____ to receive appointment notifications and medical information on my behalf.

Patient Signature _____**Date** _____