



Roseburg Audiology Center
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Roseburg, Oregon 97471
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Fax: 541-672-1142
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Patient Name:		Sex:
Address:		
City/State/Zip:		
Primary Phone #:	Secondary Phone #:	
Birth Date:	Age:	
Email:		
Emergency contact:	Relationship:	
Emergency contact phone number:		
Primary Care Dr.:		

May we leave a message on your voicemail or answering machine? ☐ 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

May we contact you via text? ☐ Yes ☐ No

(This insurance section may be left blank, if the patient is the primary card holder.)

Primary Insurance:	ID no.:
Person responsible for insurance:	
Relationship to Patient:	Birthdate:
Address(if different from patient's):	

Secondary Insurance:	ID no.:
Person responsible for insurance:	
Relationship to Patient:	Birthdate:
Address(if different from patient's):	

Reason for appointment:

How did you hear about us? (If you are an existing patient, you may skip this section)

- ☐ Referred by Physician (Name: _____)
- ☐ Internet search
- ☐ Website
- ☐ Referred by Friend/Family (Name: _____)
- ☐ Yellow pages
- ☐ Other _____

Privacy Policy (Please read carefully and sign below)

I give permission to Audiology Consultants of Southern Oregon, Inc(ACSO), dba Roseburg Audiology Center and Hearing Associates of Florence to:

- release information, verbal and written(contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services offered by ACSO. ACSO does not sell your protected health information to third parties.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- 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 and verified all of the information on this sheet, 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