Salyer Hearing Center, PLLC

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PATIENT INFORMATION

Today's Date ___________________________

Last Name ___________________________________ First Name _____________________________ MI __________

Preferred Name ______________________________ Date of Birth ______________ SS# _____________Gender ___

Mailing Address _______________________________ City _______________________ State _______ Zip ____________

Home Phone _____________________ Cell Phone ________________________ Email ____________________________

Marital Status: Single Married Divorced Widowed Spouse's Name ___________________

Employer ____ Occupation _____________________________________

Who did you bring with you today? ____________________________ Relationship to You ________________________

Emergency Contact _________________________________ Relationship ________________ Phone _________________

Primary Care Physician ______________________________

How did you hear about our practice?

Referred by Physician ________________________

Newspaper Ad

Referred by Friend __________________________

Phone Book

Billboard

Online

Other ____________________________________

By providing the above contact information, I consent that Salyer Hearing Center, PLLC may communicate with me via mail, phone or email. I consent to have phone messages concerning my personal hearing health left at the numbers I supplied. I understand that I have the right to revoke this consent at anytime by notifying Salyer Hearing Center, PLLC in writing.

Patient Signature____ Date______________________________________