QUALITY HEARING
& AUDIOLOGY CENTER

2227 N Belt Highway, St. Joseph, MO 64506
TEL 816.233.0022 FAX 816.233.0023
www.hearquality.com

Patient Information

Patient Name: First Last | Date:

Gender: Male Female | Marital Status: Married Single Widow | D.O.B. / /

Home Phone: | SS#: - -

Cell Phone: | Work Phone: | Ext.

Occupation: Prior Current

Mailing Address: | Apt/Suite:

City: | State: | Zip:

Email:

Emergency Contact: | Phone:

Relation to Patient:

Primary Care Physician: | Phone:

How did you hear about us?

Mail | Health/Senior Fair | Website | Referred by Friend: _____

Yellow Pages | Sponsored Event | Insurance | Referred by Physician: _____

Newspaper Ad | Television | Employer | Other: _____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Do you have insurance? Yes No | Do you have Medicare? Yes No

Name of Policy Holder:

Policy Number: | Group Number:

Patient Agreement

- ◯ I give permission to my hearing healthcare professional to release information-verbal and written, contained in my medical records and other documents-to my insurance company, rehab nurse, case manager, attorney, employer, healthcare providers, assignees and/or beneficiaries and all other relevant persons. Information that does not identify me as the patient may be used for quality purposes.
- ◯ I acknowledge that I have agreed that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchase made.
- ◯ I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.
- ◯ I hereby authorize the transfer of my records to be released to Dr. Pamela Shattuck Nelson, Au.D. and Quality Hearing & Audiology Center.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature of parent or guardian if patient is a minor.