Listen Hear Audiology Center
Robert Herring, Au.D.

3091 University Drive E, Ste. 410
Bryan, TX 77802
979.776.4327

PATIENT INTAKE FORM

Name: _____ Gender: _____ Date of Birth: _____
First MI Last
Address: _____
Street Apt. # City State Zip
Home Telephone: _____ Occupation: _____
E-mail Address: _____ May we send you our newsletter: ❑Yes ❑ No

Spouse's Name: _____ Daytime Telephone: _____
Spouse's Employer: _____ Date of Birth: _____

Primary Insurance Company: _____ ID# _____
Secondary Insurance Company: _____ ID# _____

In case of emergency, please contact: Name: _____ Relationship: _____
Telephone Number: _____

Who is your Primary Care Physician? _____ Phone: _____
(If you would like a copy of your results forwarded to your physician, please sign release below)

Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, a family member, or a friend, please provide their name. Thank You!

___ Physician	___ Vocational Rehabilitation	___ Health Plan/HMO
___ Audiologist	___ Yellow Pages	___ Seminar
___ Family Member	___ Newspaper	___ Internet
___ Friend/Co-worker	___ Hospital Referral	___ Other: _____

Please provide the name of the person that referred you to our office (if applicable): _____

In order for us to file your insurance claim for you the following must be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment. Further, I authorize payment of medical benefits to be made directly to Listen Hear Audiology Center, LLC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____ _____
Patient/Parent/Guardian Signature Date

Release of Medical Information

I,_____, hereby authorize Listen Hear Audiology Center, LLC to release any and all medical information in the course of my (or my child's) treatment to: _____

_____ _____
Patient/Parent/Guardian Signature Date

I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices. _____
(Initials)