THE HEARING CLINIC

PLEASE PRINT *Please fill out completely to the best of your ability.*

PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial:_____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: Male/ Female

Social Security # _____ Living facility name:_____

Home street address:_____

PO Box: _____ Apt #: _____ City:_____ State:_____ Zip code:_____

Phone numbers: Cell _____ Home_____ Work _____

Email address: _____ Best way to reach you: _____

Marital Status: single / married* / divorced / widowed / partner *Spouses name: _____

If minor, child lives with: Mother: _____ Father: _____ Both: _____ Other: _____

Primary Care Physician: _____ Referring Physician: _____

What is your preferred language? English Spanish Other: _____

Employment Status: full-time**/ part-time**/ retired / unemployed Occupation:_____

**Employer's Name: _____ **Employer's Phone#: _____

Referred By: _____ How Did you Hear About us? _____

RESPONSIBLE PARTY

Last name: _____ First name: _____ Middle initial:_____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: Male/ Female

Home street address:_____

PO Box: _____ Apt #: _____ City:_____ State:_____ Zip code:_____

Phone numbers: Cell _____ Home_____ Work _____

Email address: _____

Marital Status: single / married* / divorced / widowed / partner *Spouses name: _____

Employment Status: full-time**/ part-time**/ retired / unemployed Occupation:_____

**Employer's Name: _____ **Employer's Phone#: _____

MEDICATIONS

Do you currently take any medications: ☐Yes ☐No If yes, please complete the following. *If you need more space, please ask for second sheet.

MEDICATION Include Prescriptions, Vitamins & Over the Counter Medicaitons	DOSAGE	Route ORAL/ INJECTION	HOW MANY TIMES/DAY	REASON FOR TAKING MEDICATION

CONTACT

I HEREBY ACKNOWLEDGE THIS PERSON MAY BE CONTACTED AT ANY TIME ON MY BEHALF

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone numbers: Cell _____ Home_____ Work _____

RELEASE

Services are rendered on a Cash Basis unless previous arrangements have been made. All accounts over 30 days are subject to a Finance Charge of 1.33% per month, equal to 16% per year.

I hereby authorize payment of medical insurance benefits directly to **THE HEARING CLINIC, INC.** I understand that I am financially responsible for all charges whether or not paid by said insurance. I also authorize the release of any medical information to my insurance provider or other health care provider concerning my examination, diagnosis, and treatment. This assignment will remain in effect until revoked by me in writing.

Thank you for taking the time to fill out this release. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

SIGNATURE: _____ **DATE**: _____

Person responsible for bill (Patient/Spouse/Guardian/POA)

REVIEW AND ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed my Patient Information Sheet dated _________________ and attest the information is still true and accurate to the best of my knowledge. I also confirm that I was provided services by The Hearing Clinic on the following dates.

SIGNATURE: ____ **DATE**: ____________________________
Person responsible for bill (Patient/Spouse/Guardian/POA)

SIGNATURE: ____ **DATE**: ____________________________
Person responsible for bill (Patient/Spouse/Guardian/POA)

SIGNATURE: ____ **DATE**: ____________________________
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SIGNATURE: ____ **DATE**: ____________________________
Person responsible for bill (Patient/Spouse/Guardian/POA)

CONTACT

I HEREBY ACKNOWLEDGE THIS PERSON MAY BE CONTACTED AT ANY TIME ON MY BEHALF

Name: ____ Relationship to Patient: ______________________________

Address: ____ City: __________________ State: _______ Zip: ____________

Phone numbers: Cell __________________________ Home_____________________ Work _______________________

CONTACT

I HEREBY ACKNOWLEDGE THIS PERSON MAY BE CONTACTED AT ANY TIME ON MY BEHALF

Name: ____ Relationship to Patient: ______________________________

Address: ____ City: __________________ State: _______ Zip: ____________

Phone numbers: Cell __________________________ Home_____________________ Work _______________________

CONTACT

I HEREBY ACKNOWLEDGE THIS PERSON MAY BE CONTACTED AT ANY TIME ON MY BEHALF

Name: ____ Relationship to Patient: ______________________________

Address: ____ City: __________________ State: _______ Zip: ____________

Phone numbers: Cell __________________________ Home_____________________ Work _______________________