Southwest Hearing Center

PATIENT INTAKE FORM

Date: ______________________________

Name: ______________________________ Sex: ☐ Male ☐ Female

Address: ______________________________ City: ______________ State: ________ Zip: ______________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Long-Term Relationship

Home Phone: ______________________ Cellphone: ______________________ E-mail: ______________________

Social Security #: ______________________ Date of Birth: ______________ Age: ______________________

Reason for Visit: ______________________________ Referred by: ______________________

Primary Care Physician: ______________________________ Phone: ______________________

Employer: ______________________________ Work Phone: ______________________

Emergency Contact: ______________________ Relationship: ______________________ Phone: ____________

INSURANCE: Please present your insurance card so we may photocopy your information for billing purposes.

Name of Insurance Company: ______________________________ Insured Date of Birth: ______________________

Name of Insured (if not same as above): ______________________ Relationship: ______________________

Payment is required at the time of service. Cash, MasterCard, Visa and Discover are accepted.

I give permission to Southwest Hearing Center to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

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 understand the all the above information.

____ ______________________

Patient Signature (A copy of this signature is as valid as the original) Date