Patient Information Form

Brooks Hearing Clinic

Chart # _____ Date _____

Patient Name _____ DOB ____/____/____
First MI Last mm dd yyyy

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party _____ DOB ____/____/____
First MI Last mm dd yyyy

Home Phone #_____ Cell Phone # _____

Work Phone # _____ Patient's SSN _____ Gender_____

Email Address _____

Mailing Address _____
Street City State ZIP

Secondary Address _____
Street City State ZIP

Preferred Method of Contact ○ Home phone ○ Work phone ○ Cell phone ○ Email ○ Mail

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Partner Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

○ Mail ○ Newspaper ad ○ Promotional call ○ Radio ○ Insurance
○ Yellow pages ○ Sponsored event ○ Health/senior fair ○ Online ○ Employer
○ Referred by friend _____
○ Referred by physician _____
○ Other _____

Reason for Appointment _____

_____

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We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. So that we may provide you the highest level of service, please rate your experience of the following areas:

Location and accessibility	○ Excellent	○ Average	○ Poor
Adequate parking	○ Excellent	○ Average	○ Poor
Convenience of appointment times	○ Excellent	○ Average	○ Poor
Friendly greeting	○ Excellent	○ Average	○ Poor
Clean and welcoming environment	○ Excellent	○ Average	○ Poor

What can we do to make your next visit more comfortable?

Insurance Information

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

Please read carefully and sign below.

- I give permission to my AudigyCertified™ practice 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 authorize my AudigyCertified practice to contact me for all purposes related to my visit, including marketing-related correspondence, via email, voicemail, and text. I further understand that I can revoke my authorization to receive correspondence via email, voicemail, and text by providing written notification to my AudigyCertified practice.
- I authorize my AudigyCertified practice to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- 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 all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

I have read and understand all the above information.

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

Signature of Parent or Guardian Date