BEAVER DAM Hearing Care, LLC

Patient Information Form

Patient Name _____ DOB _____

Name of Responsible Party _____

Home Phone #_____ Cell Phone #_____ __iPhone __Android __Other

Work Phone # _____ Email Address_____

Mailing Address _____

Secondary Address _____

Preferred method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Mail

Age _____ Occupation _____ Spouse Name _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Long Term Commitment

Emergency Contact _____ Relation to Patient _____

Primary Care Physician _____ Referring Physician _____

How did you hear about us?

☐ Newspaper ☐ Insurance ☐ Yellow Pages ☐ Sponsored Event ☐ Health/Senior Fair ☐ Online

☐ Friend/Referred by Friend (Name) _____ ☐ Other_____

Reason for Appointment _____

Release of Information

I give permission 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.

Name & Relationship_____Phone #: _____

Name & Relationship_____Phone #: _____

HIPAA and Financial Information

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/Parent or Guardian_____ Date_____