Patient Information Form

Chart #_____ Date_____

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

Mailing Address_____
Street City State ZIP

Home Phone #_____ Cell Phone # _____

Email Address _____ Sex: Male Female
(Please Circle One)

Occupation _____
- ☐ Full-Time
- ☐ Part-Time
- ☐ Not Employed
- ☐ Self Employed
- ☐ Retired _____
(If retired, list prior occupation)

Preferred Method of Contact
- ☐ Home Phone
- ☐ Cell Phone
- ☐ Email

Financially Responsible Party _____
First MI Last

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

Spouse Name _____

Emergency Contact _____
(If different than your spouse)

Phone # _____

Relationship to Patient _____

Primary Care Physician _____ Phone # _____

Address _____
Street City State ZIP

Primary Care Physician's Affiliation (if any) _____

How did you hear about us?
- ☐ Mail
- ☐ Yellow Pages
- ☐ Employer
- ☐ Newspaper Ad
- ☐ Sponsored Event
- ☐ Insurance
- ☐ Promotional Call
- ☐ Health/ Senior Fair
- ☐ Radio
- ☐ Website
- ☐ Referred by Friend_____
- ☐ Referred by Physician _____
- ☐ Other _____

Reason for Appointment _____

Patient Information Form

We believe in and strive to provide a convenient location with ample parking and expect our staff to always ne professional, courteous, and helpful. To provide you with 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 acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
  - ☐ OK to leave a detailed message/voicemail at before mentioned telephone number
    OR
  - ☐ Leave a generic message with call back number only

- I give permission to Diles 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 healthcare providers, assignees, and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

- I authorize Diles Hearing Center to use and release my protected health 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 products or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.

  - ☐ Do not send any marketing information if financial remuneration is received by Diles Hearing Center (checking this box will prevent you from being notified about future available discounts or promotions)

- 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 of the information on this sheet, completed the above answers, and certify this information is true and accurate to the best of my knowledge, and I hereby give Diles Hearing Center 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)

_____
Signature of Guardian (Or Parent, if patient is a minor)