Wake Audiology & Hearing Aid Associates, PLLC
1954 S Main Street / Wake Forest, NC 27587
Phone 919-570-8311 - Fax 919-573-0797

PATIENT INFORMATION FORM

Last Name ______________________________ First________________________ MI________

Home Phone _________________ Work Phone ________________ Cell phone _________________

E-Mail Address ____

Date of Birth _____________ Age ______ Male _____ Female _____

Mailing Address ____

City __________________________ State __________________ Zip Code __________________

Employed By ___________________________ Not Employed _____ Retired _____

Name of Spouse or Significant Other ___________________________

Person to contact in case of an emergency ________________________ Phone # __________________

Primary Care Physician ____________________________ City ___________________________

Whom may we thank for referring you to our office (i.e. Physician, Family, Friend, Internet)?
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Primary Insurance __________________________Secondary Insurance _________________________
(Give copy of insurance card) (Give copy of insurance card)

Policy Holder's Name _________________________ Policy Holder's Date of Birth________________

I authorize Wake Audiology & Hearing Aid Associates, PLLC to release information requested to process insurance claims.

I have read all the information on this form and certify that this information is correct to the best of my knowledge. I will notify Wake Audiology & Hearing Aid Associates, PLLC of any changes in my health status or in the above information.

Signature ____ Date _________________________

Parent Signature if Minor ______________________________ Date _________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I received a copy of Wake Audiology & Hearing Aid Associates' Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area and the website and that any revised Notice of Privacy Practices will be made available.

_________________________________ ____________________
Signature of patient or personal representative Date

For Staff Only: Photo ID Verified: Staff Initials ______ Date _____________