Berks Hearing
PROFESSIONALS

Patient Information

Today's Date

Patient Name First Middle Last

DOB mm / dd / yyyy

Name of Responsible Party First Middle Last

Age Sex M F Occupation If retired, prior occupation

Home Phone # Cell Phone # iPhone Android Other

Work Phone # Email Address

Mailing Address Street City State Zip

Marital Status Married Single Widowed Divorced Long-term Commitment

Spouse Name

How did you hear about us?

Reason for Appointment

Contact Information

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

The staff of Berks Hearing Professionals may leave messages for appointment reminders at the following (please check all that apply)

Home phone Cell phone Work Phone Email

Please do not leave appointment reminder messages

The staff of Berks Hearing Professionals may leave detailed messages regarding my hearing health at the following: (please check all that apply)

Home phone Cell phone Work Phone Email

Please do not leave messages regarding my hearing health

The staff of Berks Hearing Professionals has permission to speak with the following people regarding my hearing health care:

Emergency Contact

Phone #

Relation to Patient

Berks Hearing
PROFESSIONALS

Insurance

Primary Care Physician Phone #

We will send a report to your primary care physician following your appointment. Please indicate if you do not want a report sent

Insurance Company Name

Member ID Group ID

Plan

Subscriber Name DOB

Relationship to Patient

Secondary Insurance

Member ID Group ID

Plan

Subscriber Name DOB

Relationship to Patient

HIPAA

I have received the **Notice of Privacy Practices** and have been provided the opportunity to review it.

I agree that all of the above information is correct to the best of my knowledge.

Patient Signature **Date**

Signature of Parent or Guardian **Date**