AUDIOLOGY ASSOCIATES
PATIENT INTAKE FORM

Today's Date____

Name (First)________________________ (M.I.)______ (Last)____________________________________

Birth Date_____________ Age____ Male___ Female____ Spouse Name___________________________

If Child- Mother's Name ______________________ Father's Name _______________________________

Street Address _____________________________ City________________State_____ Zip____________

Mailing Address (if different) ____

Home Phone_________________ Cell Phone___________________ Work Phone__________________

E –mail Address ____

Employer (if Child, parent's employer)______________________________occupation________________

Contact Person Not Living With You________________________________relationship______________

Address____Phone___________________

Primary Care Physician____________________________________Phone ________________________

How were you referred to our office?____

Specific Reason for this visit____

Which of the following do you have? _________Medicare __________Insurance __________Private Pay

Subscriber's Name______________________ ID # ___________________ Policy #__________________

Subscriber's Birth Date___________Other insurance info?______________________________________

Please provide the receptionist with your insurance card so that we may take a photocopy of it. If your insurance uses the Providence Network, they will most likely not pay for services. We are not a contracted provider with Providence Health Plans or Providence Preferred Oregon Network. If this applies to you, we will collect the fees for today's visit at the conclusion of your appointment.

I understand it is my responsibility to update my Care Provider with any new insurance or contact information.

Patient Signature (or Guardian if Child)____