AUDIOLOGY ASSOCIATES
hear today, hear tomorrow

Patient Information Form

Patient Name _____ DOB ___ / ___ / ___
Title First M Last mm dd yy

Mailing Address _____

Home Phone # _____ Phone # _____ Work Phone # _____

Email Address _____ Patient's SSN _____ Sex ☐ M ☐ F

Retired? ☐ Y ☐ N Occupation _____
If retired, prior occupation

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse/Partner Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.
If the insurance is NOT under your name, please complete this section.

Name of Subscriber _____
First MI Last

DOB ___ / ___ / ___ Relationship _____
mm dd yy

Primary Care Physician _____ Phone # _____
First MI Last Degree

Referring Physician _____ Phone # _____
First MI Last Degree

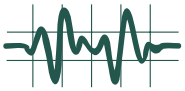
How did you hear about us?

☐ Mail ☐ Newspaper ☐ Follow-up Call ☐ Radio ☐ Insurance
☐ Yellow Pages ☐ Educational Class ☐ Health Fair ☐ Website ☐ Event
☐ Physician Referral
☐ Referred by Friend _____
First MI Last

For internal use only: Medical Group Specialty

Name _____ Group _____ Insurnace Affiliation _____

Patient Information Form



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We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be 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
Convenienve of appointment times	☐ Excellent	☐ Average	☐ Poor
Friendly greeting	☐ Excellent	☐ Average	☐ Poor
Clean and welcoming environment	☐ Excellent	☐ Average	☐ Poor

If we scored “Average” or “Poor” above, what can we do differently?

Please read carefully and sign below

- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy at this office.
- I understand and agree that, regardless of my insurance status, I am ultimiately responsible for the balance of my bank 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 hereby give Audiology Associates 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.)

Date