PATIENT INFORMATION FORM

Chart # ______________________ Date ______________

If patient is under the age of 18, a responsible party must complete this section.

Name of Responsible Party: ______________________ DOB: ___/___/______
First MI Last — MM DD YYYY

Relation to Patient: ______________________

Patient Name: ______________________ DOB: ___/___/______
First MI Last — MM DD YYYY

Home Phone # ______________ Cell Phone # ______________

Work Phone # ______________ Patient's SSN ______________ Sex ○ M ○ F

Email Address ______________________

Mailing Address ______________________
Street City State Zip

Secondary Address ______________________
Street City State Zip

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

Age __________ Occupation ______________________
(If retired, prior occupation)

Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Spouse Name ______________________

Emergency Contact ______________________ Phone # ______________
(Name/Relation)

Primary Care Physician ______________________ Phone # ______________

How did you hear about us?

○ Mail ○ Newspaper ad ○ Promotional call ○ Radio ○ Insurance

○ Yellow Pages ○ Sponsored event ○ Health/senior fair ○ Online ○ Employer

○ Referred by friend ______________________

○ Referred by physician ______________________

○ Other ______________________

Reason for Appointment ______________________

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PROFESSIONAL SPEECH & HEARING SPECIALISTS

We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. To ensure we are providing you with the highest level of service, please rate your experience of the following areas:

Location and accessiblity	○ 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?

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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 give permission to Professional Speech & Hearing Specialists 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 health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- 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 the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

Please read carefully and sign below.

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Patient Signature (A copy of this signature is as valid as the original) Date

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Signature of Parent or Guardian Date