

PATIENT INTAKE FORM

This form complies with the Federal Health Insurance Portability and Accountability Act (HIPAA). This is a secure form; the information that you enter here will be seen only by the staff of our practice.

First name: _____

Last name: _____

Middle Initial: _____

Address line 1: _____

Address line 2: _____

City: _____

State: _____ Zip: _____

Phone number: _____

Email address: _____

Gender: Male: Female:

Birth date: _____

Marital Status: Single: Married:

Current Occupation: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Relationship: _____

Referred By: _____

Referring Physician: _____

ABOUT YOUR HEARING

Do you have any of the following symptoms?

Difficulty in hearing: No: Both: Left: Right:

Noise in hearing: No: Both: Left: Right:

Pain in hearing: No: Both: Left: Right:

Drainage from your ears: No: Both: Left: Right:

Fullness and stuffiness in your ears: No: Both: Left: Right:

Dizziness or balance problems? : Yes: No:

Had a previous hearing exam? : Yes: No:

Previous Exam by:

Worn hearing aids before? : Yes: No:

Previous hearing aid details:

FINANCIAL INFORMATION

Cash or Insurance:

PRIMARY INSURANCE

Insurance Name:

Insurance ID #:

Insurance Group #:

Primary Subscriber's Name:

SECONDARY INSURANCE

Insurance Name:

Insurance ID #:

Insurance Group #:

Secondary Subscriber's Name:
