Audiology & Hearing Associates, Inc

Patient Information Sheet

☐ PREVIOUS PATIENT ☐ NEW PATIENT

Patient Name: ______________________________ Date of Birth: __________ SSN: ________________

Address: ________________________________ City: ____________________ State: _____ Zip:________

Primary Phone # ____________________ (home / cell) Alternate Phone # ____________________ (home / cell)

Place of Employment: ________________________________ Work Phone: ____________________

Family Physician: ____________________________ Physician Phone number: ____________________

E-mail address: (Will not be shared) ____

Note: By providing my e-mail address I understand that I will receive occasional information regarding appointments, newsletters, and/or promotions.

How did you hear about us? ◻ Website ◻ Facebook ◻ Insurance ◻ Google ◻ Friend/Family ◻ Other ______________

HIPAA - Patient Privacy Information

To whom may we talk to about your general medical condition, appointments, or other hearing health care information?

Emergency Contact: ____________________ Relationship: __________________ Phone: ________________

Name:____________________________ Relationship: __________________ Phone: ________________

Name:____________________________ Relationship: __________________ Phone: ________________

Can confidential messages (i.e appointment reminders) be left on your answering machine? Yes ◻ No ◻

The greatest compliment our practice can receive is the referral of a friend or family member by one of our patients!

WHO do you know that we may be able to help?

Name:____ Phone: ____________________

Can we use your name when contacting them? Yes ◻ No ◻

CONSENT AND RELEASES

Authorization to pay Benefits to Physicians: I hereby authorize the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that I authorize Audiology & Hearing Associates, Inc. to submit claims for benefits, services rendered or services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and I will be bound by this signature as though the undersigned had personally signed the particular claim. **I understand that I am responsible for any balance not covered by insurance.** I assign all hearing benefits to Audiology & Hearing Associates, Inc.

Signature: **X**____ Date:________________________

(Patient, Parent, legal guardian or authorized person)

Please turn this page over

Audiology & Hearing Associates, Inc

8019 East Market St. Warren, OH 44484

PH: 330-372-4500 FAX: 330-372-4540

CONSENT AND RELEASE OF MEDICAL INFORMATION

Authorization to Obtain/Release Medical Records: I authorize Audiology & Hearing Associates, Inc or any person designated by them to obtain/release copies of my complete audiological medical records for my continued care and treatment to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me/my dependent. This authorization for release of information covers all past, present and future periods and is enforced unless revoked by myself in writing and received by the Practice's Privacy Official at the following address: 8019 East Market St. Warren, OH 44484.

By signing this form, I authorize disclosure of my audiological health information. I understand that I am under no obligation to sign this form and that my refusal to sign will not affect my ability to obtain treatment and care.

Patients Name (Please Print): **X**____ D.O.B ___________________________

Signature: **X**____ Date:____________________________

(Patient, Parent, legal guardian, or authorized person)