Patient Information Form

(Please fill out front & back)

CHESAPEAKE HEARING CENTERS
"Audiologists Helping People!"
www.helpyourhearing.com

Patient Name _____ DOB _____
First MI Last

Sex ◯ M ◯ F Is this your legal name? ◯ Yes ◯ No

If not, what's your legal name _____
First MI Last

Primary Contact (if not self) _____Relation to patient_____
First Last

Primary Contact Phone Number _____

1st Phone#_____ 2nd Phone# _____ 3rd Phone# _____

E-Mail _____@_____

Mailing Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Occupation _____ (if retired, prior occupation)

Marital Status ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Long-Term Commitment

Emergency Contact _____ Phone# _____
First Last

Relation to patient _____

Primary care physician (Full name) _____

I would like a report to be sent to ◯ primary care physician ◯ Other _____

How did you hear about us? _____

Reason for appointment _____

_____

Insurance Information

Primary insurance _____

Subscriber's Name (if different than patient) _____DOB _____
First MI Last

Patient's relationship to subscriber ◯ Spouse ◯ Child ◯ Other

Secondary insurance (If applicable) _____

Subscriber's name (If different) _____DOB _____
First MI Last

Patient's relationship to subscriber ◯ Spouse ◯ Child ◯ Other

***Person responsible for bill (if not self). ***

Name _____ DOB_____
First Last

Address _____
Street City State Zip

Please read carefully and sign below

- I give permission to my AudigyCertified™ practice 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 healthcare providers, assignees, and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

_____ ***To refuse permission to release records, initial here.***

- 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 hereby give my AudigyCertified practice permission to treat my concerns. Effective period for: All past, present, and future periods. This authorization shall be in force and effect until the event of my death at which time this authorization expires.

I have read and understand all the above information.

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

_____ Date _____
Signature of parent or guardian

I authorize Chesapeake Hearing Centers to release information to the following individuals as well:

_____ Relation to patient _____
First Last

_____ Relation to patient _____
First Last