

# Patient Information Form

(Please fill out front & back)

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 \_\_\_\_\_

1<sup>st</sup> Phone# \_\_\_\_\_ 2<sup>nd</sup> Phone# \_\_\_\_\_ 3<sup>rd</sup> 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.**

Chesapeake Hearing Centers occasionally video or audio records patients and providers for training purposes only. These recordings are used inside of our practice and will not be posted or used in any way other than for training.

Please sign indicating that you are aware of this policy \_\_\_\_\_

If you do NOT wish to be recorded please sign 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