Audiology HEARS

Patient Intake Form

First Name _____ Last Name _____ MI _____

Date of Birth _____ Last 4 SSN _____ Female ◯ Male ◯

Email _____

Home Phone #_____ Cell Phone # _____

How would you like to be contacted? Home ◯ Cell ◯ Email ◯

Home Address _____City _____ State _____ Zip _____

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Employment Status ◯ Full Time ◯ Part Time ◯ Retired ◯ Unemployed ◯ Student

Occupation _____

Primary Insurance Company _____ Subscriber ID# _____

Subscriber Name _____ Subscriber Date of Birth _____

Relationship to Insured ◯ Self ◯ Spouse ◯ Child

Secondary Insurance Company _____ Subscriber ID _____

Subscriber Name _____ Subscriber Date of Birth _____

Relationship to Insured ◯ Self ◯ Spouse ◯ Child

Primary Care Physician _____ Phone # _____

Referring Physician _____ (If different from primary physician)

Who can we release information to:

Name _____ Name _____

Relationship _____ Relationship _____

Phone # _____ Phone # _____

Emergency Contact Name _____ Phone # _____

Relationship _____