AUDIOLOGY ASSOCIATES

hear today, hear tomorrow

Patient Name:					
DOB:			Email:		
Address:					
Home Phone:	Cell Phone:		Work Phone:		
PCP:	Referring Physician:				
Retired: ☐YES ☐ NO	Employer:		Occupation:		
Spouse/Partner Name:			Contact Phone:		
Emergency Contact/Relationship			Contact Phone:		
Insurance Information Please give your insurance cards to our front office staff so we can make a copy for our records. ***If the insurance is NOT under your name, please complete this section:*					
Name:	DOB:		Relationship:		
How did you hear about us? Referred by Friend:_____					
☐Class/Event	☐Insurance	☐Yelp	☐Google	☐Website	☐Other
If amplification is necessary, what is most important to you in order 1-5? *1= Least Important, 5 = Most Important*					
_____Visability		_____Ease of Use		_____Minimal Maintenance	
_____Expense		_____Ability to Wear (Comfort)		_____Sound/Quality	

Patient has executed HIPAA authorization and agrees to receive 3rd party marketing materials.

☐Agrees ☐Declines 3rd party marketing

Please read carefully and sign below

- I acknowledge that the Health Insurance Portability & Accountability Act (HIPAA) policy has been explained to me and offered to me by 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 Audiology Associates permission to treat my concerns.

_____ _____

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

1111 Sonoma Avenue, Suite 316, Santa Rosa, CA 95405, (707) 523-4740 Office (707) 523-0231 Fax