ALABAMA HEARING ASSOCIATES

**Patient Information**

Patient Name: _____ (Last) _____ (First) Date: _____ Age: _____

Gender: Male ☐ Female ☐ Marital Status: Married ☐ Single ☐ Widowed ☐ D.O.B.: ___ / ___ / ___

Home Phone: _____ SS#: ___ - ___ - ___

Cell Phone: _____ Work Phone: _____ EXT: _____

Occupation: Prior ☐ Current ☐ _____

Mailing Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Email: _____

Emergency, Contact: _____ Phone: _____

Relation to Patient: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us?

☐ Mail ☐ Website ☐ Referred by Friend: _____

☐ Yellow Pages ☐ Insurance ☐ Referred by Physician: _____

☐ Newspaper Ad ☐ Employer ☐ Other: _____

☐ Radio

## Insurance Information

*Please give your insurance information to our front office staff so we can make a copy for our records.*

Do you have Insurance? **Yes / No** Do you have Medicare? **Yes / No** D.O.B.: ___ / ___ / ___

Name of Policy Holder: _____

Policy Number: _____ Group Number: _____

## Patient Agreement

I give permission to my hearing healthcare professional to release information–verbal and written, contained in my medical records and other documents–to my insurance company and healthcare providers.

I acknowledge that I agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchases made.

I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.

I have been advised by Alabama Hearing Associates that the Food and Drug Administration has determined that my best health interests would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish to undergo a medical evaluation before purchasing a hearing aid.

Signature_____ Date _____

Signature_____ Date _____

*SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR*