Spencer Audiology Clinic · 2114 James St. · Bellingham, WA 98225 · P: 360-527-8525 · F: 360-527-8525
SpencerAudiology@gmail.com

Patient Information Form

Date ___________________

Patient Name ____
First MI Last

Preferred Name_______________________ Date of Birth ___/___/______ Age _____Gender O Female O Male

Home Phone #_______________________________ Cell Phone #______________________________________

Work Phone #________________________________ Email ____

Mailing Address ____
Street

____
City State Zip

How did you hear about us?

O Walk-in O DVR O Employer O HLA O Insurance O Mail O Newspaper Ad

O Senior Center O Yellow Pages O Lions Club O Assisted Living Facility ____________________

O Online _________________________(website/search engine) O Event ______________________________

O Family/Friend/Patient____

O Physician/Facility ________________________________ O Other ___________________________________

Employment Status: O Retired O Full-time O Part-time O Unemployed O Student

Occupation/Employer (if ***RETIRED*** previous occupation): ____

Marital Status: O Married O Single O Widowed O Divorced O Long-Term Commitment

Spouse/Partner Name _____________________________ Emergency Contact ____________________________

Phone #____ Relation to Patient____________________________

Primary Care Physician and/or Facility ____

Insurance Information: Please let our front office staff know if you have insurance so that we can make a copy for our records.

Assignment and Release: Please read below carefully

I, the Patient or Guardian, certify that the information on this form is true to the best of my knowledge. I authorize Spencer Audiology Clinic to release any information necessary to process an insurance claim on my behalf. I also authorize my insurance benefits to be paid directly to Spencer Audiology Clinic and I understand that I am financially responsible for all charges whether or not paid by my insurance. I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I have read and understand the above information.

Patient Signature ____ Date _______________________

Legal Guardian Signature ____