Patient Information Form

SPENCER AUDIOLOGY CLINIC

Patient Name _____ Date _____
First MI Last

Preferred Name _____ Date of Birth ___/___/_____ Age _____ Gender ◯ Female ◯ Male

Home Phone # _____ Cell Phone # _____

◯ Please check if we can leave a detailed message.

Work Phone # _____ Email _____

Mailing Address _____
Street City State Zip Code

How did you hear about us?

◯ Walk-in ◯ DVR ◯ Employer ◯ HLA ◯ Insurance ◯ Mail ◯ Newspaper Ad ◯ Senior Center ◯ Yellow Pages

◯ Lions Club ◯ Assisted Living Facility _____ ◯ Online _____ (website/search engine)

◯ Event _____ ◯ Family/Friend/Patient _____

◯ Physician/Facility _____ ◯ Other _____

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

Occupation/Employer (if **RETIRED**): _____

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ 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 _____

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