THE HEARING CENTER
A DIVISION OF OHIO HEAD & NECK

Account # _____ Date_____

Patient Information Form

Patient Name _____ DOB _____/_____/_____
First MI Last mm dd yyyy

Address _____
Street City State Zip Code

Home Phone #_____ Cell Phone #_____

Email _____ Marital Status _____Occupation _____

Primary Care Physician _____ How did you hear about us? _____

Insurance Information
Please give your insurance information and photo ID to our front office staff so we can make a copy for our records.

Primary Insurance _____Secondary Insurance (if applicable) _____

Reason for appointment _____

Have you had your hearing tested in the last 6 months? Y N Do you wear hearing instrument(s)? Y N

List of medications_____

_____

Please read carefully, initial, and sign below.

_____ I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

_____ I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account at The Hearing Center for any professional services rendered or items purchased.

_____ The information I have provided is true and correct to the best of my knowledge and I give professionals at The Hearing Center permission to evaluate and treat my hearing health concerns.

_____ I give permission to The Hearing Center to release my medical information (verbal and written) to my insurance company, healthcare providers, and all other related persons.

_____ Initial here if you refuse permission to release records.

I understand the above information.

_____
Patient or guardian signature Date