Patient Information Form

Date _____

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

Preferred name _____ Sex ○ M ○ F

Name of Responsible Party _____
First MI Last

Home Phone #_____ Cell Phone # _____ ○ iPhone ○ Android ○ Other

Work Phone # _____ May we leave a message with your spouse, responsible party, or on your voicemail? ○ Yes ○ No

Email Address _____

Mailing Address _____
Street City State ZIP

Secondary Address _____
Street City State ZIP

Preferred Method of Contact ○ Home phone ○ Work phone ○ Cell phone ○ Email ○ Mail ○ Text

Age _____ Occupation _____
(If retired, prior occupation)

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ _____ _____
City State

How did you hear about us?

○ Mail ○ Newspaper ad ○ Promotional call ○ Radio ○ Insurance
○ Yellow pages ○ Presentation ○ Health/Senior fair ○ Online ○ Employer
○ Referred by friend _____
○ Referred by physician _____
○ Other _____

Reason for Appointment _____

_____

BLUE WAVE hearing centers

Patient Information Form (continued on back)

Patient Information Form

We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. So that we may provide you the highest level of service, please rate your experience of the following areas:

Location and accessibility	○ Excellent	○ Average	○ Poor
Adequate parking	○ Excellent	○ Average	○ Poor
Convenience of appointment times	○ Excellent	○ Average	○ Poor
Friendly greeting	○ Excellent	○ Average	○ Poor
Clean and welcoming environment	○ Excellent	○ Average	○ Poor

What can we do to make your next visit more comfortable?

Insurance Information

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

Please read carefully and sign below.

- I give permission to Blue Wave Hearing Centers to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize Blue Wave Hearing Centers to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.
- I acknowledge that 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 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 I hereby give Blue Wave Hearing Centers permission to treat my concerns.

I have read and understand all the above information.

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

Signature of Parent or Guardian Date