Date _____

Patient Information

( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Dr. Sex: ( ) Male ( ) Female

Last Name _____ First Name _____

Spouse or Parent's Name (s) _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail Address _____ Family Doctor _____

Date of Birth _____ Preferred method of contact: _____

Who may we thank for referring you to us?

___ Friend _____ ___ Doctor _____

___ Internet ___ Newspaper ___ Other _____

Reason for visit:

___ Dizziness ___ Hearing Loss ___ Hearing Aids ___ Tinnitus

___ Other _____

ON A SCALE OF 1-10, 1 BEING THE WORST AND 10 BEING THE BEST, HOW WOULD YOU RATE YOUR OVERALL ABILITY TO HEAR?

_____

The Notice of Privacy Practices is available upon request. You may have access to these practices to retain for your records. This practice has the right to change this Notice at any time.

Patient/Guardian Signature _____ Date _____

Payment is expected at the time of service. I hereby assign payment to the undersigned. I understand I am financially responsible for any non-covered services. I also hereby authorize the release of any information needed to process the claims.

Signature _____ Date _____