ROBERTSON
HEARING CLINIC
Diagnostic & Rehabilitative Audiology

Patient Information Form

Patient Name _____ Date _____ / _____ / _____
First MI Last MM DD YYYY

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party _____
First MI Last

Home Phone # _____ Cellphone # _____ ☐ iPhone ☐ Android ☐ Other

Work Phone # _____ Patient's SSN _____ Sex ☐ M ☐ F

Email Address _____

Mailing Address _____
Street City State Zip

Secondary Address _____
Street City State Zip

Preferred Method of Contact ☐ Home phone ☐ Work phone ☐ Cellphone ☐ Email ☐ Mail

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 _____ Phone # _____

How did you hear about us?

☐ Mail ☐ Newspaper Ad ☐ Promotional Call ☐ Radio ☐ Insurance

☐ Yellow pages ☐ Sponsored Event ☐ Health/Senior Fair ☐ Website ☐ Employer

☐ Referred by friend _____

☐ Referred by physician _____

☐ Other _____

Reason for Appointment _____

_____

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 in 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 to our front office staff so we can make a copy for our records.

Please read carefully and sign below.

- I give permission to my practice 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 my practice to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from or on behalf of the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy for 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 my hearing care provider 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 Patient or Guardian

Date