NEW PATIENT

Patient Information Form

Rametta Audiology & Hearing Aid Center

YOUR INFORMATION

PATIENT NAME

First | MI | Last

DOB

mm / dd / yyyy

CHECK THE BOX OF YOUR PREFERRED CONTACT NUMBER:

☐ Home Phone #

☐ Cell Phone #

☐ Work Phone #

Patient's SSN

Gender

Email Address

MAILING ADDRESS

Street | City | State | ZIP

SECONDARY MAILING ADDRESS

Street | City | State | ZIP

Age

Occupation (If retired, please list prior occupation)

Marital Status

Partner Name

Emergency Contact

Relation to Patient

Phone #

Primary Care Physician

Phone #

HOW DID YOU HEAR ABOUT US?

☐ Mail
☐ Yellow pages
☐ Newspaper ad
☐ Referred by a friend
☐ Sponsored event
☐ Health/senior fair
☐ Radio
☐ Referred by physician
☐ Insurance
☐ Employer
☐ Online
☐ Other

Reason for Appointment

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 The 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 The Practice to contact me for all purposes related to my visit, including marketing-related correspondence, via email, voice mail, and text. I further understand that I can revoke my authorization to receive correspondence via email, voice mail, and text by providing written notification to The Practice.
- I authorize The 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 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 answers, and certify this information is true and correct to the best of my knowledge. I hereby give my hearing care provider permission to treat my concerns.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION.

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

Date

Signature of Parent or Guardian

Date