

Date: \_\_\_\_\_



# Patient Information Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
                    First                    MI                    Last

Mailing Address \_\_\_\_\_  
  Street  City  State                    Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ SSN \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_  
(If retired, prior occupation)

Marital Status       Married     Single     Widowed     Divorced

Spouse Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

## How did you hear about us?

- Mail                       Newspaper Ad                       Radio                       Insurance
- Yellow Pages     Sponsored Event                       Website                       Health/Senior Fair
- Referred by Friend / Physician (Name) \_\_\_\_\_
- Other \_\_\_\_\_

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

- I give my permission to Stanford Hearing Aids 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 healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

\_\_\_\_\_ Initial to refuse permission to release records.

- 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 hereby give Stanford Hearing aids permission to treat my concerns.

Date: \_\_\_\_\_

**Patient Signature or Patient's parent or Guardian** (A copy of this signature is as valid as the original)

**Date**