INTAKE FORM

PREFERENCE - check one: Mr. _____ Mrs. _____ Miss _____ Ms. _____

NAME:_____ DATE OF BIRTH:___/___/___ AGE:____
First MI Last

ADDRESS:_____
Street Apt # City State Zip

PHONE:_____ EMPLOYER NAME:_____

EMAIL ADDRESS:_____ EMPLOYER PHONE:_____

CIRCLE ONE: Male Female CIRCLE ONE: Married Single Widow

EMERGENCY INFORMATION:
In case of emergency, please contact: Name:_____Relationship:_____

Telephone Number:_____

PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS ON SPOUSE'S INSURANCE PLAN:

Spouse's Name:_____ Spouse's Daytime Telephone:_____

Spouse's Employer:_____ Spouse's Date of Birth:____/____/____

PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS A MINOR (under 18 years of age)

Father's Name_____
Date of Birth: ____/____/____
Home Phone (if different)_____
Work Phone_____
Employer:_____

Mother's Name:_____
Date of Birth: ____/____/____
Home Phone (if different)_____
Work Phone_____
Employer:_____

Who is your primary care physician? _____Phone:_____

How did you hear about our office? _____

Are you a veteran? _____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I authorize payment of medical benefits to be made directly to the East Penn Hearing Center for services rendered. This authorization shall remain in effect until otherwise stated in writing,

_____ ____/____/____
Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I would like a copy of my test results sent to the physician listed above. I would also like to have this information forwarded to:_____

_____ ____/____/____
Patient/Parent/Guardian Signature Date