PATIENT INTAKE FORM

Patient Name: First: _____Middle: _____ Last: _____

Date of Birth: ____/____/_____ Age: _____ Sex: M__ F__ Marital Status S M D W

Street Address: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell:_____

Email Address: _____ Occupation: _____

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Spouse Name: _____

Spouses Employer: _____

Primary Insurance: _____ID#_____

Secondary Insurance: _____ ID #_____

Emergency Contact: _____Phone #_____

Primary Care Physician: _____ Phone _____

NPI #_____

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Referred by: Physician_____ Family Member_____ Vocational Rehabilitation _____ Newspaper_____ Hospital Referral Service_____ Internet_____ Audiologist_____ Friend/Co-worker_____ Yellow Pages_____ Health Plan_____ Other_____

Name of Referral (if applicable):_____

In order for this office to file an insurance claim for you, the following must be signed. I authorize the release of any medical and/or other information necessary to process any medical claim. I authorize payment of medical benefits to be paid directly to South Dayton Hearing Aids & Audiology for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent signature:_____

Date:_____