Personal History

HILL
HEAR BETTER

Patient Information

Chart #: _____ Date: _____

Patient Name: _____ DOB: ____/____/____
First MI Last M D Y

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

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ SSN: _____ Sex: M F

E-Mail: _____ @ _____

Mailing Address: _____
Street City State Zip

Age: _____ 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 ☐ Promotional Call ☐ Radio ☐ Insurance

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

☐ Referred by Friend: _____

☐ Referred by Physician: _____

☐ Other: _____

Reason for Appointment: _____

_____

Turn over...

Personal History

Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of 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 healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

☐ 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 and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give my practice permission to treat my concerns.

I have read and understand all the above information.

_____ _____

A copy of this signature is as valid as the original — Date

Signature of Parent or Guardian if patient is a minor: _____