HIGHLINE
Hearing Professionals

Patient Information Form

Patient Name ______________________________ DOB ____/____/________
First MI Last mm dd yyyy

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

Name of Responsible Party ______________________________ DOB ____/____/________
First MI Last mm dd yyyy

Home Phone # ______________________ Cell Phone # ______________________

Work Phone # ______________________ Gender ______________ Age ________

Email Address ______________________________

Mailing Address ______________________________
Street City State ZIP

Secondary Address ______________________________
Street City State ZIP

Occupation ______________________________
(If retired, prior occupation)

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Emergency Contact ______________________ Phone # ______________________

Relation to Patient ______________________________

Primary Care Physician ______________________ Phone # ______________________

How did you hear about us?

○ Mail ○ Newspaper ad ○ Doctor ○ Insurance
○ Yellow pages ○ Health/senior fair ○ Online
○ Referred by friend ______________ ○ Referred by physician ______________
○ Other ______________________________

Reason for Appointment ______________________________

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Preferred Method of Contact ○ Home phone ○ Work phone ○ Cell phone ○ Email

We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous and helpful. So that we may provide you 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?

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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 understand that Highline Hearing Professionals will use and disclose health information about me.
- I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken works and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, and similar types of health information.
- I also understand that I can request a written description of how Highline Hearing Professionals will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Highline Hearing Professionals, and my rights to regarding my health information.
- I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.
- I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Highline Hearing Professionals is not required by law to agree to such request.

I give Highline Hearing Professionals permission to discuss my health information with the following people

Name____________________ Relationship____________________ Phone____________________

Name____________________ Relationship____________________ Phone____________________

I have read and understand all the above information.

____

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

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Signature of Parent or Guardian Date