Patient Information Form

HearWell CENTER
Better Hearing For Life.

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 # _____ Sex ○ M ○ F

Email Address _____

Mailing Address _____
Street City State ZIP

Secondary Address _____
Street City State ZIP

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

Age _____ Occupation _____
(If retired, prior occupation)

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

Partner 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 ○ Online ○ Employer
○ Referred by friend _____
○ Referred by physician _____
○ Other _____

Reason for Appointment _____

_____

Patient Information Form

HearWell CENTER
Better Hearing For Life.

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?

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 AudigyCertified™ 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 health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.
- I authorize my AudigyCertified practice to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.

We here at HearWell Center will not sell your private information to commercial entities of any type. Instead, we work with third parties in the creation of marketing materials, like newsletters or postcards, to keep you informed of developments in hearing health care that may be important to you. For example, communication about updates to your hearing products, yearly checkup notifications, sales/discounts, etc. We take your privacy very seriously and provide only the minimum information necessary to any companies marketing with us. We also only work with companies that are governed under the privacy laws of HIPAA to ensure that your information remains protected.

I have read and understand all the above information.

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

Signature of Parent or Guardian Date