Patient Information Form

Date _____

Patient Name_____DOB_____/____/_____
First MI Last

If patient is under the age of responsible party must fill out remainder of this section

Name of Responsible Party_____
First MI Last

Home Phone #_____ Cell Phone #_____ _____

Work Phone # _____Patient's SSN_____ Sex Male Female
Circle one

Email Address_____

Mailing Address_____
Street City State Zip

Secondary Address_____
Street City State Zip

Preferred Method of Contact
o Home o Phone o Text o Email o Mail

Age_____ Occupation_____

Marital Status
o Married o Single o Long Term Commitment o Widowed o Divorced

Spouse Name_____

Emergency Contact_____ Phone #_____

Relation to Patient_____

Primary Care Physician_____ Phone #_____

How did you hear about us?
o Yellow Pages o Event o Health/Senior fair o Website o Employee
o Mail o Newspaper Ad o Promotional call o Radio o Insurance

Referred by friend_____

Referred by Physician_____

Other_____

Reason for Appointment_____

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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 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 Timpanogos Hearing and Balance 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 (HIPPA) 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 am financially responsible for any property of Timpanogos Hearing &Balance that is damaged or lost while in my possession.

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my permission to treat my concerns.

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

Timpanogos Hearing & Balance