Timpanogos Hearing & Balance

Layne Garrett, AuD, FAAA | **William Sparrow,** AuD

Patient Information Form

Date _____

Patient Name _____ DOB ____ / ____ / ____

First MI Last

If patient is under the age of 18, responsible party must fill out remainder of this section

Patient of Responsible Party _____

First MI Last

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Patient's SSN _____ Sex ☐ Male ☐ Female

Email Address _____

Mailing Address _____

Street City State Zip

Secondary Address _____

Street City State Zip

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

Age _____ Occupation _____

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

Spouse Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us?

☐ Yellow Pages ☐ Event ☐ Health/Senior Fair ☐ Website ☐ Employee

☐ Mail ☐ Newspaper ☐ Promotional Call ☐ Radio ☐ Insurance

Referred by friend _____

Referred by Physician _____

Other _____

Reason for Appointment _____

Patient Information Form

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 with the highest level of service, please rate your experience in the following areas:

How did you hear about us?

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 healthcare providers 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, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give 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 Patient or Guardian Date