Patient Information Form

Date___________________________

Patient Name (First, Middle, Last):____

Date of Birth____/____/_______ Patient Sex (circle) Female Male

Street Address: ____

City____State__________________Zip____________

Cell Phone: ________________________________ Home Phone:______________________________

Email address: ____

Occupation____

Emergency Contact____________________________________Phone_______________________________

Primary Care Physician____

How Did You Hear About Us?____

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 (available in office upon request)

- 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.

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

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Signature of Parent or Guardian Date