COMPREHENSIVE Hearing Solutions

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PATIENT INTAKE FORM

Name: _____ **Preferred Name:** _____
(First) (Middle Initial) (Last)

Date of Birth: _____/_____/_____ **Gender:** M F **Marital Status:** S M D W

Mailing Address:

_____
(Street) (Apt #)

_____
(City) (State) (Zip)

Mobile Phone: _____ **Home Phone:** _____

Mobile (Circle one): iPhone Android Smartphone Flip None

Work Phone: _____ **Occupation:** _____

E-mail Address: _____

Can we contact you by the following methods? Please circle by each option. ***Email?*** Y N ***Text?*** Y N ***Call?*** Y N

Our office sends out appointment reminders, notifications and other important information via email and text message. You may miss important information if we are not allowed to communicate with you by text or email.

Spouse/Partner's Name: _____ **Phone:** _____

In case of emergency, notify: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Insurance: Please give your information to our front office staff so we can make a copy for our records.

Name of Primary Insurance: _____ **Name of Secondary Insurance:** _____

If the insurance is NOT under your name, please complete this section.

Name of Subscriber: _____ **Date of Birth:** _____ **Relationship:** _____

The above is true to the best of my knowledge. I understand that I am responsible for informing the office staff of any changes to the information above.

Patient Signature: _____ **Date:** _____