

# PATIENT INTAKE FORM

**FOR OFFICE USE ONLY**

Cycle ID: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
(First) (MI) (Last)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

**Primary Resident Information**Address: \_\_\_\_\_  
(Street) (Apt #) (City) (State) (Zip)

Home Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Mobile: iPhone\_\_ Android \_\_ Windows \_\_ Smartphone \_\_

E-mail Address: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

**Snowbird Resident Information**

From (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_ to (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
(Street) (Apt #) (City) (State) (Zip)

Home Telephone: \_\_\_\_\_

Occupation: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

**General Information**

Spouse's Name: \_\_\_\_\_

Daytime Telephone: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

In an emergency notify: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Person Responsible: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Contract No.: \_\_\_\_\_ Group No.: \_\_\_\_\_ Subscriber No.: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Person Responsible: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Contract No.: \_\_\_\_\_ Group No.: \_\_\_\_\_ Subscriber No.: \_\_\_\_\_

What is your reason for today's visit? \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

I understand I am responsible for my deductible, co-pays, and/or money my insurance company(s) says that I owe. I authorize the release of any medical information to my personal physician and to the insurance company if needed to process this claim and related claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to My Hearing Centers for services rendered. This authorization shall remain in effect until otherwise stated in writing.

**I certify that the above information is correct and that I have read and fully understand the above statements.**

Authorized Signature \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_