MY HEARING CENTERS
We Change Lives Through Better Hearing

PATIENT INTAKE FORM

FOR OFFICE USE ONLY

Sycle 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: _____/_____/_____