PHILIP AUDIOLOGY
& HEARING AID SERVICES
Professional Mobile Hearing Care You can Trust

Patient Intake Form

Patient Full Name:_____ Preferred Name:_____

DOB:_____ Sex: M / F _____

Address: City State Zip_____

Home #:_____ Work #_____: Cell #: _____

Email Address:_____ Can we contact you via email _____

If you have a cell number is ok to text you for information related to our clinic?

_____

Employment status? _____

Marital Status _____

Current/Past Occupation_____

What motivated you to come in today? _____

How did you hear about us? _____

Physician information:

Primary Care Physician _____ Contact info _____

Referring Physician (if different from primary): _____Contact info _____

Emergency Contact:

Name:_____Relationship:_____Ph:_____

Authorize to release information?? Yes or No _____

I authorize:

- the release of information back to my physician or other referral source.
- payment of medical benefits to Philip Audiology for services rendered to my dependent or me.
- I have been offered a copy of Philip Audiology & Hearing Aid Service 's Health Insurance Portability & Accountability Act (HIPAA) Privacy Notice.

Signature (Patient or Responsible Party) _____ Date _____