CAROLINA
Hearing and Tinnitus

Patient Information Form

Office ______________ Date ______________

Patient Name ____ DOB ____/____/______
First Middle Initial Last mm dd yyyy

If patient is under the age of 18, responsible party must complete remainder of this section.

Name of Responsible Party ____
First Middle Initial Last

Home Phone # ______________ Mobile # ______________ ○ iPhone ○ Android ○ Other

Work Phone # ______________ Patient's SSN ______________ Sex ○ M ○ F

Email Address ____

Mailing Address ____
Street City State ZIP

Secondary Address ____
Street City State ZIP

Preferred Method of Contact: ○ Home phone ○ Work phone ○ Cell phone ○ Email ○ Mail

Age ________ Occupation ____
(If retired, indicate prior occupation)

Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Spouse Name ____

Emergency Contact Person ______________________________ Phone # ______________
First and Last Name

Relation to Patient ____

Primary Care Physician ______________________________ Phone # ______________

How did you hear about us?

○ Mail ○ Newspaper ad ○ Promotional call ○ Insurance ○ Radio
○ Yellow pages ○ Sponsored event ○ Health/senior fair ○ Employer ○ Website
○ Referred by friend ____
○ Referred by physician ____
○ Other ____

Reason for Appointment ____

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Patient Information Form

We strive to provide a convenient location with ample parking, and we expect our staff to always be professional, courteous, and helpful. So that we may provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	○ Excellent	○ Average	○ Poor
Adequate parking	○ Excellent	○ Average	○ Poor
Convenience of appointment times	○ Excellent	○ Average	○ Poor
Friendly greeting	○ Excellent	○ Average	○ Poor
Clean and welcoming environment	○ Excellent	○ Average	○ Poor

What could we do to make your *next* visit more comfortable?

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 Carolina Hearing and Tinnitus, PC 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 authorize Carolina Hearing and Tinnitus, PC to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services.
- I understand that the practice may receive financial remuneration in exchange for making the marketing communication from (or on behalf of) the third party whose product or service is being described. I understand that this marketing authorization is in effect until a revocation is received by the practice.
- I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.
- 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 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 hearing care provider permission to treat my concerns.

I have read and understand all the above information.

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

Signature of Parent or Guardian Date