Hearing and Audiology

for your hearing health

PATIENT INTAKE FORM

Patient Name: _____ Sex: F M

FIRST MIDDLE LAST

Date of Birth: ___/___/___ **Age:** _____ **Marital Status:** _____

Address: _____

STREET APT# CITY STATE ZIP

Home Telephone: _____ **Cell Phone:** _____

Email Address: _____ **Occupation:** _____

Employer: _____ **Phone:** _____

Primary Care Physician: _____

FIRST LAST

Primary Complaint: _____

Background Information:	Right	Left
Hearing Difficulty		
Ringing, Roaring, other noise		
Pressure / Fullness		
Ear Infections		
Ear Surgery		
Ear Pain		

History of:	Yes	No
Loud Noise Exposure		
Head Injury		
Vertigo / Dizziness		
Kidney Disease		
Heart Disease		
Diabetes		
Family History of Hearing Loss		

How did you hear about us?

PHYSICIAN NEWSPAPER INTERNET / GOOGLE AUDIOLOGIST YELLOW PAGES HEALTH PLAN

ANOTHER PATIENT: _____ OTHER: _____

I acknowledge that I was offered a copy of WNC Audiology's privacy practices. I give WNC Audiology permission to contact me or my family members, care givers, etc. by telephone, email, and regular mail, or leave messages on my answering machine regarding appointment information, hearing health issues, hearing instruments and technology.

I authorize the release of any medical and other information necessary to process my medical claim. Further, I authorize payment of medical benefits to be made directly to WNC Hearing and Audiology for services rendered. This authorization shall remain in effect unless otherwise stated in writing by myself.

I acknowledge that in the event my insurance does not cover services, I will be responsible for payment.

_____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE DATE