Patient Information Form

Fox Valley Hearing Center, Inc.

Patient Name _____ DOB:_____

Insured Name _____

Home Phone#_____ Cellular#_____ ☐ iPhone ☐ Android ☐ Other

Work Phone # _____ Email Address_____

Mailing Address _____

Secondary Address_____

Preferred method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Mail

Occupation _____ Spouse Name _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Long Term Commitment

Emergency Contact _____ Phone#_____ Relationship to Patient_____

Primary Care Physician _____Clinic Name/Location_____

How did you hear about us?

☐ Newspaper ☐ Insurance ☐ Yellow Pages ☐ Sponsored Event ☐ Health/Senior Fair ☐ Online

☐ Primary Care Physician (Name)_____ ☐ Other_____

☐ Friend/Family Member (please list their name(s)_____

Reason for Appointment? _____

Release of Information

I give permission 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 health care providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

Name & Relationship_____Phone # _____

Name & Relationship_____Phone # _____

HIPAA and Financial Information

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I understand that if services rendered today are not covered by my insurance policy, that I am responsible for payment. I also understand that it is my responsibility, not the responsibility of the provider, to know the benefit provided by and limitations of my health insurance policy.

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 authorize the release of any medical or other information necessary to process claims. I also request payment of government and insurance benefits to myself or to the party (supplier) who accepts assignments of service.

I have read and understand all the above information

Patient Signature/Parent or Guardian_____ Date_____