Patient Information Form

HEARING consultants
1000 Lake St Louis Blvd, Lake St Louis, MO 63367
TheHearingConsultants.com
314.394.1911

Date _____

Patient Name _____
First MI Last

Preffered Name _____ DOB ____/____/____ Age _____ Sex ☐ ☐
mm dd yyyy

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Email _____

Mailing Address _____
Street City State ZIP

How did you hear about us?

☐ Mail ☐ Promotional call ☐ Insurance ☐ Sponsored event
☐ Health/senior fair ☐ Website ☐ Employer
☐ Referred by friend _____
☐ Referred by physician _____
☐ Other _____

Employment Status ☐ Retired ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student

Occupation/Employer (if retired previous occupation) _____

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

Spouse/Partner Name _____

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

Insurance Information: Please let our front office staff know if you have insurance so that we can make a copy for our records.

Plan name _____ Policy number _____

Group number _____ Phone number from back of the card _____

Subscriber Name _____ Address _____ DOB ____/____/____

Assignment and Release: Please read below carefully

I, the Patient or Guardian, certify that the information on this form is true to the best of my knowledge. I authorize Hearing Consultants to release any information necessary to process an insurance claim on my behalf. I also authorize my insurance benefits to be paid directly to Hearing Consultants and I understand that I am financially responsible for all charges whether or not paid by my insurance. I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I have read and understand the above information.

Patient Signature _____ Date _____

Legal Guardian Signature _____ Date _____

Companion Questionnaire

If your companion does not currently use technology, please skip this section.

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My companion has difficulty hearing when using technology...

	Always	Sometimes	Rarely	N/A
1. While in background noise	☐	☐	☐	☐
2. In the car	☐	☐	☐	☐
3. On the phone	☐	☐	☐	☐
4. In a conference room	☐	☐	☐	☐
5. In a restaurant	☐	☐	☐	☐
6. While listening to music	☐	☐	☐	☐
7. While watching TV	☐	☐	☐	☐
8. In group conversations	☐	☐	☐	☐
9. In conversations with their spouse or family	☐	☐	☐	☐
10. In conversations with women or children	☐	☐	☐	☐

Additional Comments _____

Medication Documentation

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In order for us to provide the best health care, it is important for us to know the medications you are taking. Please fill out this form and bring with you to your appointment.

Below, please list each medication you are currently taking including the following: prescriptions, over-the-counter medicine, herbals and vitamin/mineral/dietary supplements. Thank you!

Medication Name	Dosage	Frequency	Oral, shots, dermal, etc.	Condition it is treating

Patient Signature _____ Date _____