Patient Information Form

HEARING consultants
300 Medical Plaza, Ste 122, Lake St. Louis, MO 63367
12255 De Paul Dr, Ste 860, Bridgeton, MO 63044
314.394.1911 **TheHearingConsultants.com**

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 _____