Associated Hearing PROFESSIONALS

16219 Baxter Road
Chesterfield, MO 63017
Phone: 636.778-9232
Fax: 636.778.9236

950 Francis Place, Ste 200
Clayton, MO 63105
Phone: 314-725-2686
Fax: 314-725-2680

PATIENT INFORMATION – PLEASE PRINT

LAST NAME_____FIRST NAME_____MIDDLE_____GENDER_____

HOME # (_____)_____ CELL# (____)_____Is it ok to text for appointment confirmation_____
WORK# (___)_____ EMAIL ADDRESS_____

BIRTHDATE_____ MARITAL STATUS : Single Married Divorced Widow Spouse's Name_____
PATIENT
ADDRESS_____CITY/STATE/ZIP_____

BILLING ADDRESS IF NOT THE SAME AS ABOVE_____

EMPLOYMENT: FULL TIME PART TIME RETIRED NOT EMPLOYED OCCUPATION _____
EMPLOYER_____

EMERGENCY CONTACT_____

RELATIONSHIP TO PATIENT_____PHONE #_____

MAIN REASON YOU SCHEDULED TODAY'S APPOINTMENT_____

DO YOU HAVE A PACEMAKER_____OTHER MEDICAL CONDITIONS_____

PLEASE NOTE CURRENT MEDICATIONS _____

WOULD YOU LIKE YOUR HEARING EVALUATION RESULTS SHARED WITH YOUR ENT OR PRIMARY CARE PHYSICIAN? Y / N

DOCTOR_____ADDRESS_____ PHONE #_____

TO WHOM MAY WE RELEASE INFORMATION? *Necessary to share information with even family members.*

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

MAY WE LEAVE A MESSAGE ON YOUR VOICE MAIL SYSTEM Y / N EMAIL Y / N

WHO REFERRED YOU TO ASSOCIATED HEARING PROFESSIONALS? Name_____ Relationship_____

IF ADVERTISEMENT INDICATE WHERE_____

INSURANCE: PRIMARY_____ SECONDARY_____ *please give us cards to copy*

PRIMARY MEMBER PLEASE CIRCLE ONE: Self or Spouse If spouse or parent Name_____ Date of Birth_____

EMPLOYER of Spouse or Parent if they are the primary card holder_____

I hereby authorize the release of any information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or that portion not covered by my insurance. I further understand that if there is any delay or dispute regarding my insurance, I will be responsible for payment of my account within a 30 day period of time.

Signature of Responsible Party_____ Date_____