GROSSE POINTE AUDIOLOGY

INTAKE FORM

PATIENT INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell Phone #:_____

Work Phone #:_____ Is it ok to call you at work? ☐ Yes ☐ No
If yes, is it ok to say it is Grosse Pointe Audiology calling? ☐ Yes ☐ No

Date of Birth:_____ Age:_____ E-Mail:_____

Referred By:_____

Primary Care Physician:_____ Phone Number_____

Address:_____

CONTACT PERSON

☐ Spouse ☐ Relative_____ ☐ Friend ☐ Other

Name:_____

Home Phone #:_____ Cell/Work Phone #:_____
Is it ok to call at work? ☐ Yes ☐ No

HEARING AID INFORMATION

Have you ever worn hearing aids? ☐ Yes ☐ No

Where were your hearing aids from? _____

Who is the Manufacturer of your hearing aids? _____

How old are your hearing aids? _____

Comments: _____

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.

I understand that I am responsible for my bill.

I authorize you to act as my agent in helping me obtain payment from my insurance company.

I permit a copy of this authorization to be used in place of the original.

I hereby authorize Grosse Pointe Audiology, LLC, to release to my insurance company any information acquired in the course of my examination or treatment.

I authorize my insurance company to pay my insurance benefits to Grosse Pointe Audiology, LLC, for service rendered and I am responsible for any unpaid balance.

Name:_____ Date:_____

Signature:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ By checking this box and signing below, I acknowledge that I received a copy of Grosse Pointe Audiology's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website and that any revised Notice of Privacy Practices will be made available.

_____ _____

Printed name of patient or personal representative Date

_____ _____

Signature of patient or personal representative Date