

NORTHLAND HEARING ASSOCIATES, INC.

PATIENT INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____
Social Security # _____

Address: _____
Street Apt # City State Zip

Home Telephone: _____ Occupation: _____

E-MAIL ADDRESS: _____

Spouse's Name: _____ Daytime Telephone: _____

Spouse's Employer: _____ Date of Birth: _____

Spouse's Social Security # _____ (only needed if spouse is insurance policyholder)

Primary Insurance Company: _____ ID# _____

Secondary Insurance Company: _____ ID# _____

Spouse D/B _____

In case of emergency, please contact: Name: _____ Relationship: _____

Telephone Number: _____

Who is your primary care physician? _____ Phone: _____

(If you would like a copy of your test results forwarded to your physician, please sign the release below)

Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

- Physician Vocational Rehabilitation Health Plan/HMO
Audiologist Yellow Pages Attended Seminar
Family Member Newspaper Ad/Article Internet
Friend/Co-worker Hospital Referral Service Other: _____

Please provide the name of the person that referred you to our office (if applicable): _____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to Northland Hearing Associates, Inc. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize Northland Hearing Associates, Inc. to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above. I would also like to have this information forwarded to: _____

Patient/Parent/Guardian Signature Date