AUDIOLOGY ASSOCIATES OF HOLLADAY

Patient Information Form

Chart #: ________ Date: ________________

Print Patient Name: ____ DOB: ____________________
First MI Last MM DD YYYY

If patient is under the age of 18, responsible party must complete remainder of this section:

Name of Responsible Party: ____
First MI Last

Home Phone #: ______________________ Cellphone #: ______________________

Work Phone #: ______________________ Patient's SSN #: ______________________ Sex: ☐ M ☐ F

Email: ____

Mailing Address: ____
Steet City State Zip

Secondary Address: ____
Steet City State Zip

Age: ______________________ Occupation: ______________________

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

Spouse Name: ____

Emergency Contact: ______________________ Phone #: ______________________

Relation to Patient: ____

Primary Care Physician: ______________________ Phone #: ______________________

How did you hear about us?

☐ Mail ☐ Yellow Pages ☐ Newspaper Ad ☐ Sponsored Event ☐ Promotional Call

☐ Health/Senior Fair ☐ Radio ☐ Website ☐ Insurance ☐ Employer

☐ Referred by Friend: ______________________ ☐ Referred by Physician: ______________________

☐ Other: ____

Reason for Appointment: ____

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We believe in and strive to provide a convenient location with ample parking and expect our staff to always be professional, courteous helpful and to provide you with the highest level of service. Please rate your experience of the following areas:

Location and accessibility	☐ Excellent	☐ Average	☐ Poor
Adequate parking	☐ Excellent	☐ Average	☐ Poor
Convenience of appointment times	☐ Excellent	☐ Average	☐ Poor
Friendly greeting	☐ Excellent	☐ Average	☐ Poor
Clean and welcoming environment	☐ Excellent	☐ Average	☐ Poor

What can we do to make your next visit more comfortable? ____

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Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Please read carefully and sign below:

I give permission to Audiology Associates of Holladay to release information, verbal and written (contained in my medical record and other related information), to my insurance company, rehab nurse, case manager, attorney, employer, related health care providers, assignees, beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

_____ **Initial to refuse permission to release records**

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services or purchases rendered.

I have read all the information on this sheet, completed the above answers and certify this information is true and correct to the best of my knowledge and hereby give Audiology Associates of Holladay permission to treat my concerns.

I have read and understand all the above information.

____ ____________________

Patient Signature (A copy of this signature is as valid as the original) Date

____ ____________________

Signature of Parent of Guardian Date