GREGORY W. HALL, M.A.
HEARING HEALTH CARE
SAN MARCOS

AudigyCertified™

Patient Information Form

Date:_____

Patient Name:_____DOB:_____
First MI Last

Name of Responsible Party:_____
First MI Last

Home Phone #:_____Cell Phone #:_____

Work Phone #:_____Sex: Male_____Female_____

eMail Address:_____Martial Status:_____

Mailing Address:_____

Secondary Address:_____

Preferred Method of Contact: Home phone:___Work phone:___Cell phone:___eMail:___Mail:__

Spouse's/Partner's Name:_____Phone #_____

Emergency Contact Name:_____Phone #:_____
(If different from spouse/partner)

Relation to Patient:_____How did you hear about us?_____

Primary Care Physician:_____Phone #:_____

Reason for Appointment:_____

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

Gregory W. Hall, M.A.
hearingsanmarcos@gmail.com
www.hearingsanmarcos.com

San Marcos 910 W San Marcos Blvd, Ste 102
Ph: 760.471.1196 **Fax:** 760.471.1550

PLEASE READ CAREFULLY AND SIGN BELOW (HIPAA/Privacy)

- I give permission to Hearing Health Care San Marcos 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 professionals, assignees and/or beneficiaries, and all other related persons.

- I acknowledge that I may ask at any time for a copy of HIPPA "Notice of Privacy Practices" to read and review.

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

- Yes____No____ I give permission for us to contact you periodically regarding your hearing health care, services, and hearing care products. How would you like to be contacted? eMail____Text____Phone____Mail____(Check all that apply.)

- I would like to receive my appointment reminders via eMail____Text____Phone____

- 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 I hereby give my hearing care provider 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.)

_____

Signature of Parent or Guardian