Welcome to Worth Hearing Center

PATIENT INFORMATION

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss ( ) Dr. ( ) Sr. ( ) Rev. **Gender**: ( ) Male ( ) Female

Legal Name: Last______________________________, First_____________________________, Middle Initial______

Date of Birth: ___________________ Preferred Name: _______________________ Preferred Language: _______________

Address: ____

City: _______________________________ State: _____________ Zip code: ______________

Home Phone: _______________________ Work Phone: ______________________ Cell Phone: _______________________

Other Phone: _______________________ e-mail address: ____

HOW DID YOU HEAR ABOUT US?

( ) Family physician ( ) Ear physician ( ) Advertisement
( ) Yellow pages ( ) Facebook or social media ( ) Yelp
( ) Website ( ) Television Commercial
( ) Patient (name) _______________________ ( ) Other (please describe) ___________________________

EMPLOYMENT STATUS

( ) Full Time ( ) Part Time **Employer: ________________________________ Phone number___________________

( ) Unemployed ( ) Retired ( ) Self Employed ( ) Active Military ( ) Disabled

Choose One If Applies: ( ) Child ( ) Full Time Student ( ) Part Time Student

MARITAL STATUS: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Partner ( ) Widowed

RESPONSIBLE PARTY AND CONTACT PERSON

Emergency Contact: Name ____

Relationship: _________________________ Phone:________________________________

Responsible Party: (if other than patient; or if patient is a child, responsible parent/guardian)

Name ____

Relationship: ___________________ Phone:________________________________

Address: ____

City: _______________________ State: ________ Zip code: _________________

PLEASE FILL OUT BOTH SIDES

*Primary Care Physician: ___________________________

*Referring Physician: ____________________________

INSURANCE INFORMATION

ARE YOU ON MEDICARE? ( ) YES ( ) NO

Primary INSURANCE:____

Primary Card Holder's Name: (if other than self)_______________________ Date of Birth _________________________

Secondary INSURANCE:____

Primary Card Holder's Name (if other than self):________________________ Date of Birth ________________________

Tertiary INSURANCE :____

Primary Card Holder's Name (if other than self) _________________________ Date of Birth ________________________

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• The undersigned hereby authorizes any insurance payment directly to Worth Hearing Center.

• I understand that I am responsible for any balance that is not covered by my insurance. I understand that when balances are not paid in full, I will be responsible for any collections and/or late fees.

• If the patient is under 18 years of age, the undersigned is responsible for any balance due that is not covered by insurance.

•I give permission to Worth Hearing Center 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 healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

• A Notice of Privacy Practices is available for any patient who would like one. The notice describes our policies relating to the privacy of health related information. The notice also describes your rights with respect to your health information. I have been informed that a Notice has been made available to me.

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 Worth Hearing Center permission to treat my concerns.

Signature ____ Date _________________________

Please list your current Medications below or provide the front office with a list.

Medication	Dosage	Frequency

Please use another paper if needed