Pt. intake sheet(Blank)

Advanced Hearing Plus
816 Beltine Rd.
Springfield, OR 97477
Phone: 541-746-7671
Fax: 541-746-2625
www.advancedhearingplus.com

Patient Name:		**Sex:**
Address:		
City/State/Zip:		
Primary Phone #:		**Secondary Phone #:**
Birth Date:	**Age:**	**Primary Care Dr.:**
Email:		
Emergency contact:		**Relationship:**
Emergency contact phone number:		

Primary Insurance:	
Person responsible for insurance:	
Relationship to Patient:	**Birthdate:**
Address(if different from patient's):	
Person Responsible Employed by:	**Occupation:**

Secondary Insurance:	
Person responsible for insurance:	
Relationship to Patient:	**Birthdate:**
Address(if different from patient's):	
Person Responsible Employed by:	**Occupation:**

May we leave a message on your answering machine? ___ Yes ___ No

May we contact you at work? ___ Yes ___ No

May we leave a message with anyone who answers the phone numbers provided? ___ Yes ___ No

May we contact you via e-mail? ___ Yes ___ No

(Please turn the page over and complete the other side)

Reason for appointment:

_____

_____

_____

How did you hear about us?

___ Referred by Friend/Family _____

___ Referred by Physician _____

___ Yellow Pages ___ Insurance ___ Mail ___ Employer ___ Newspaper ___ Radio ___ Website

___ Other _____

Privacy Policy (Please read carefully and sign below)

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

- I authorize Advanced Hearing Plus to use and release my protected health information, i.e., my contact information, for marketing related to hearing care products or services offered by Advanced Hearing Plus. Advanced Hearing Plus does not sell your protected health information to third parties.

- 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 and verified all of the information on this sheet, 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) Date

_____ _____

Signature of Parent or Guardian Date