



PATIENT INTAKE FORM

Today's Date
Patient Preferred Name
Patient's Legal Name
Date of Birth
Gender
Address
City
State
Zip
Main Phone #
Other Phone #
Appointment reminders
Employer/School
Marital Status
Name of Spouse
Anyone with you today?
Relationship
Preferred Language
Name of Family Physician
Permission to release a copy of test information to family physician
Email
Do you wish to be included for marketing Campaigns?
How did you hear about us?

Insurance Information

Primary
Insurer Name
Insurance ID No.
Insurer Phone
Insurance Group No.
Secondary
Insurer Name
Insurance ID No.
Insurer Phone
Insurance Group No.
Other

Patient Authorizations

Insurance & Financial Authorizations: I authorize the release of any information by Pee Dee Hearing Center to determine Insurance benefits and assignment of benefits for payment of service provide to me. I request that my insurance carrier make payment to Pee Dee Hearing Center. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time of services are rendered and in accordance with Pee Dee Hearing Center Audiology's Insurance policy. Refunds from service charge on a credit card will be returned to the same credit card.
Mail/Email Authorization: I authorize Pee Dee Hearing Center to contact me via mailing, phone, text and email addresses given above. I understand my information will never be sold; however, I may receive future promotional materials from Pee Dee Hearing Center, including information from third parties' companies.
Treatment Authorization: I hereby give Pee Dee Hearing Center consent for audiological treatment deemed advisable & necessary in the diagnosis and treatment of my hearing condition.
Medical Records Authorization: I authorize the release of medical records information to 1) the above-name insurance companies 2) any physician who has participated in my health care, and 3) to any physician who I may subsequently be referred to.

Please list Emergency contact info below:
Name
Relationship
Phone
Name
Relationship
Phone

Patient Signature or Legal Custodian
Date:



**Acknowledgement & Request
of Privacy Practice**

By signing below, I acknowledge that I have been given the option to request a copy of the PEE DEE HEARING CENTER notice of Privacy Practices.

I understand that my health information may be used and disclosed by the PDHC. I understand that I may obtain access and control this information.

_____ **YES** I would like a copy of the **PDHC** Privacy Practices

_____ **NO** I would NOT like a copy of the **PDHC** Privacy Practices

Please list who you give permission to contact us and have access to your pertinent medical information below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Print Name of Patient

Print Name of Guardian/Care Giver

Signature of Patient/ Guardian/Care taker

Date