Patient History Questionnaire

Date____

Patient Name____ DOB ___/___/___
First MI Last

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

Name of Responsible Party_______________________________________ DOB ___/___/___
First MI Last

Home Phone #__________________________ Cell Phone # ________________________________

Work Phone #______________________ Responsible Party SSN___________________ Sex M F

Email address____

Mailing address____
Street City State Zip

Age___________ Occupation____
(If retired, prior occupation)

Marital Status O Married O Single O Widowed O Divorced

Spouse Name____

Emergency Contact Name & Phone #: ____

Relation to Patient____

Primary Care Physician______________________________ Phone__________________

Insurance information

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

Primary Insurance Carrier:___________________________ Name of Insured:__________________

Relationship to Insured: O Self O Spouse O Child Insured's Date of Birth:______________

Secondary Insurance Carrier:_________________________ Name of Insured:__________________

Relationship to Insured: O Self O Spouse O Child Insured's Date of Birth:______________

How did you hear about us?

O Mail O Newspaper Ad O Promotional Call O Radio O Insurance
O Yellow Pages O Sponsored Event O Health/Senior Fair O Website O Employer

O Referred by Friend____

O Referred by Physician____

O Other____

Reason for Appointment____

Patient History Questionnaire

Please read carefully and sign below

- I give permission to Professional Hearing Services Inc. 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.

  _____ 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 of 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 Professional Hearing Services Inc. permission to treat my concerns.

I have read and understand all of the above information.

____ Date__________________________

A copy of this signature is as valid as the original

____ Date__________________________

Signature of Parent or Guardian

Please complete this section when you arrive at our office:

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

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

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

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