PATIENT INTAKE FORM

Date: ____/____/____
Last Name: _____ First: _____ M.I: _____
Birth Date: ____/____/____ Age: _____ Social Security #: _____-_____-_____
Home Phone: _____ Cell Phone: _____ E-Mail Address: _____
Address: _____
Street City State Zip
Employer: _____ Phone: _____

Spouse's Name: _____ Daytime Telephone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Care Physician: _____ Phone: _____

Insurance Information

Primary : _____ Policy Holder Name: _____ID#: _____
Secondary: _____ Policy Holder Name:_____ID#: _____
Policy Holder Date of Birth: ____/___/____

Who referred you to our office?

We like to know how our patients find our practice. If you learned about our office another way, it is helpful that we know as well. Please check below the MOST influential referral source that brought you to our office. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

☐Physician ☐Vocational Rehabilitation ☐Health Plan/HMO
☐Audiologist ☐Yellow Pages ☐Family Member
☐Newspaper Ad/Article ☐Internet ☐Hospital Referral Service
☐Friend/Co-Worker ☐VA Service ☐Other: _____

**Referral Name (if applicable): _____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to Central Texas Hearing Center for services rendered. This authorization shall remain in effect until I state otherwise, in writing.

_____ ____/___/____
Date