GRUSECKI AUDIOLOGY & HEARING AID SERVICES

Grusecki Audiology & Hearing Aid Services, LLC

623-583-1737
Fax: 623-583-0607

Jamie Grusecki, Au.D.
Doctor of Audiology

www.GruseckiAudiology.com

12691 W Smokey Dr #131 ♦ Surprise, AZ 85378

PATIENT INTAKE FORM

Personal Information **WINTER VISITOR? ☐ YES ☐ NO**

NAME:_____
FIRST **MI** **LAST**

PREFERRED NAME:_____

ADDRESS:_____ _____
APT #

CITY:_____**STATE:**_____ **ZIP CODE:**_____

TELEPHONE #: (_____**)**_____-_____ **ALTERNATE #: (**_____**)**_____-_____

EMERGENCY CONTACT:_____ **TELEPHONE #: (**_____**)**_____-_____

EMAIL:_____

DATE OF BIRTH:_____ **AGE:**_____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ PARTNER

PRIMARY CARE PHYSICIAN:_____

HOW DID YOU HEAR ABOUT US:_____

Insurance Information

☐ EMPLOYED PART TIME/FULL TIME ☐ RETIRED ☐ STUDENT
(circle one)

PRIMARY **INSURANCE:**_____ **PRIMARY INSURANCE ID#**_____

SECONDARY **INSURANCE:**_____ **SECONDARY INSURANCE ID#:**_____

ARE YOU THE POLICY HOLDER: ☐ YES ☐ NO
IF NO, WHAT IS THE POLICY HOLDERS NAME:_____

IF NO, WHAT IS THE POLICY HOLDERS DATE OF BIRTH: _____ / _____/ _____

RELATIONSHIP TO PATIENT:_____ **SAME ADDRESS: ☐ YES ☐ NO**

IF DIFFERENT, WHAT IS ADDRESS? _____

*** ***Please provide receptionist with insurance card(s) AFTER form is completed*** ***

As a professional courtesy, Grusecki Audiology & Hearing Aid Services, LLC will submit all claims to your insurance provider, but this does not guarantee payment.

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. I understand and accept that I am responsible for payment of any non-covered services or procedures, deductibles, co-pays, and/or other co-insurance amounts.

_____ _____ / _____ / 20_____
Patient/Parent/Guardian Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I acknowledge that I received a copy of Grusecki Audiology & Hearing Aid Services, LLC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, the website (if applicable) and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- This Notice informs me how Grusecki Audiology & Hearing Aid Services, LLC will use my health information for the purposes of my treatment and/or payment for my treatment.
- This Notice explains in more detail how Grusecki Audiology & Hearing Aid Services, LLC may use and share my health information for other than treatment, payment, and health care operations.
- Grusecki Audiology & Hearing Aid Services, LLC will also use and share my health information as required/permitted by law.

_____ _____
Printed name of patient or personal representative Date

_____ _____
Signature of patient or personal representative Date