HOLLAND
HEARING CENTER

ADULT PATIENT INFORMATION

Date:_______________________

Patient Name___________________________________ Date of Birth_____/_____/____ Age _____ Male Female

Address____ City_________________ State _____ Zip__________

SSN_ XXX-XX-________ Home Phone_(____)______-__________ Cell Phone_(____)______-__________

Email______________________________ Marital Status: S M D W Spouse's Name_____________________________

**Primary Care Physician (Required)______________________________ Office ___________________________________

PCP phone_(____)_____-________ PCP fax if known_(____)______-________Date last seen by PCP_______________

Emergency Contact

Name:_________________________ Primary Contact:_(___)______-___________ Cell_(____)_____-__________

Relationship to Patient: ____________________ Can records be released to this person if necessary? Yes No

How did you hear about us? Please check all that apply and provide name(s) where applicable.

_____Physician Referral __________________________ _____Friend _____________________________

_____Newspaper _____Phone Book _____Mail _____Website _____Facebook _____TV

_____Other ____

Financial Agreement/Insurance: Insurance Carrier:____

Policy Holder's Name: _______________________________ Date of Birth: ___/____/______ SSN:____-____-______

Relationship to Patient: Self Spouse Child Employer Other (please specify)_________________________

Your employer___________________________________ Occupation____

Work Phone_(____)_____-__________

Holland Hearing Center will file to your insurance company as a courtesy. Our office participates with some insurance companies, but not all. It is the patient's responsibility to verify benefits of coverage. By signing, I authorize Holland Hearing Center to release all information necessary to secure the payment of benefits from my insurance company. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Please Initial 3 places and Sign at the bottom:

__________ **Consent to Treatment:** **I agree to the audiological services necessary for care and treatment provided under the general and special instructions of the audiologist.**

___________ **Privacy Practices:** **Privacy Practices have been reviewed and made available to me.**

___________ **Release of Information:** **I, the undersigned, hereby authorize Holland Hearing Center to release my records to the physician(s) listed above and provide/request updated medical records needed to aid in my evaluation and treatment.**

****Responsible Party Signature (required)____ Date_______________**