Associated Hearing PROFESSIONALS

16219 Baxter Road
Chesterfield, MO 63017
Phone: 636.778-9232
Fax: 636.778.9236

950 Francis Place, Ste 200
Clayton, MO 63105
Phone: 314-725-2686
Fax: 314-725-2680

## PATIENT INFORMATION – PLEASE PRINT

LAST NAME_____FIRST NAME_____ MIDDLE _____ GENDER _____

HOME # (_____)_____ CELL# (____)_____ WORK# (___)_____

BIRTHDATE_____ MARITAL STATUS_____ E-MAIL ADDRESS _____

PATIENT
ADDRESS_____CITY/STATE/ZIP_____

OCCUPATION_____EMPLOYER_____

EMERGENCY
CONTACT_____

RELATIONSHIP TO PATIENT _____ PHONE #_____

MAIN REASON YOU SCHEDULED TODAY'S APPOINTMENT _____

DO YOU HAVE A PACEMAKER_____ OTHER MEDICAL CONDITIONS _____

PLEASE NOTE CURRENT MEDICATIONS _____

_____

**WOULD YOU LIKE YOUR HEARING EVALUATION RESULTS SHARED WITH YOUR ENT OR PRIMARY CARE PHYSICIAN? Y / N**

DOCTOR_____ADDRESS_____ PHONE #_____

**TO WHOM MAY WE RELEASE INFORMATION?** *Necessary to share information with even family members.*

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

**MAY WE LEAVE A MESSAGE ON YOUR VOICE MAIL SYSTEM Y / N EMAIL Y / N**

**WHO REFERRED YOU TO ASSOCIATED HEARING PROFESSIONALS?**

NAME_____RELATIONSHIP_____

ADVERTISEMENT_____WHERE_____

**INSURANCE:** *please give us cards to copy*
PRIMARY
MEMBER_____RELATIONSHIP_____

BIRTHDATE_____EMPLOYER_____

*I hereby authorize the release of any information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or that portion not covered by my insurance. I further understand that if there is any delay or dispute regarding my insurance, I will be responsible for payment of my account within a reasonable period of time.*

**Signature of Responsible Party_____ Date_____**