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

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

PATIENT INFORMATION – PLEASE PRINT

LAST NAME_______________________FIRST NAME_______________________MIDDLE_________GENDER_________

HOME # (_____)____________________ CELL# (____)______________Is it ok to text for appointment confirmation_______
WORK# (___)_______________________ EMAIL ADDRESS_______________________________________

BIRTHDATE________________ MARITAL STATUS : Single Married Divorced Widow Spouse's Name________________
PATIENT
ADDRESS_________________________________CITY/STATE/ZIP_______________________________

BILLING ADDRESS IF NOT THE SAME AS ABOVE_______________________________________

EMPLOYMENT: FULL TIME PART TIME RETIRED NOT EMPLOYED 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______________

IF ADVERTISEMENT INDICATE WHERE____

INSURANCE: PRIMARY______________________ **SECONDARY**______________________ *please give us cards to copy*

PRIMARY MEMBER PLEASE CIRCLE ONE: Self or Spouse If spouse or parent Name________________ Date of Birth________

EMPLOYER of Spouse or Parent if they are the primary card holder____

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 30 day period of time.

Signature of Responsible Party_______________________________________ **Date**_________________________