Professional Hearing

Professional Hearing Healthcare Associates

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www.prohearinghealth.com 33 Lyman Street, Suite 103A - Westborough, MA 01581

Patient Information Form

Last Name _____ First Name _____ Preferred Name_____

Birth Date _____ Sex _____ Home Phone _____ Cell Phone _____

Address _____ City _____ Zip Code _____

Email _____ Family Relation's Name _____

Primary Care Physician _____ Address _____

Referring Physician _____ Address _____

Whom may we thank for referring you to our office? _____

Insurance

Primary Insurance _____ Insurance ID# _____

Name of Policy Holder _____ Policy holders date of birth _____

I authorize Professional Hearing Healthcare Associates to release information requested with regard to processing my claims.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet, and certify that this information is correct to the best of my knowledge. I will notify Professional Hearing Healthcare Associates of any changes in my health status or in the above information.

Signature _____ Date _____

Parent Signature if Minor _____ Date _____

Federal HIPPA Notice of Privacy Practices

I hereby acknowledge that I have read Professional Hearing Healthcare Associates, Inc. Notice of Privacy Practices and I authorize the release of my Protected Health Information to the listed entities.

Signature: _____ Date: _____

Parent Signature if Minor: _____ Date: _____