Patient Intake Form

Patient Name: _____ Gender: _____

Date of Birth: _____ Marital Status: _____

Address: _____ City, State and Zip: _____

Primary Phone: _____ ☐ Cell ☐ Home Secondary Phone: _____

Email Address: _____ Appointment Reminders: ☐ Email ☐ Call ☐ Text

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

How Did You Hear About Our Clinic?

Please choose the MOST influential source of information about how you heard about our practice:

☐ Physician: _____ ☐ Online (Google/Facebook) ☐ Direct Mail

☐ Family Member: _____ ☐ Newspaper/Magazine ☐ Radio

☐ Insurance Plan: _____ ☐ Other: _____

☐ Friend: _____

Insurance Information

Primary: _____ ID#: _____ Group: _____

Insured (if not patient): _____ DOB: _____ Employer: _____

Secondary: _____ ID#: _____ Group: _____

Insured (if not patient): _____ DOB: _____ Employer: _____

Insurance Claim Filing Disclosure

In order for us to file your insurance claim, the following statement must be signed:

I authorize the release of any medical and/or other information necessary to process my medical Claim. Further, I authorize payment of medical benefits to be made directly to D&A Financial Services, Inc. DBA Able Hearing for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Patient/Guardian Signature: _____ Date: _____

Persons With Whom We May Share Personal Health Information

I hereby authorize D&A Financial Services, Inc. DBA Able Hearing to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above. I would also like to give the following person access to my medical records:_____

Patient/Guardian Signature: _____ Date: _____

I have been given the opportunity to read or obtain a copy of the Notice of Privacy Practices: _____ (initials)