PHYSICIANS
HEARING SERVICES

New Patient Intake Form

TO BE COMPLETED BY PATIENT

Patient Information

Patient Name _____
First Last MI

Street Address _____

Mailing Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security # _____

Marital Status ____ Single ____ Married ____ Other Sex ____ Male ____ Female

Occupation _____ Employer _____

Parent/Guardian/Spouse Information

Full Name _____
First Last MI

Home Address _____ Apt. # _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security # _____

Relationship to Patient _____ Sex ____ Male ____ Female

Occupation _____ Employer _____

Insurance Information

	Primary Insurance Coverage	Secondary Insurance Coverage
Insurance Company		
Subscriber Name		
Subscriber ID #		
Group or Policy #		
Group Name		
Relationship to Patient		
Subscriber's Date of Birth		
Subscriber's Social Sec #		
Subscriber's Address (If not listed above)		

Other Information

How was patient referred to us? ☐ Advertisement ☐ Friend ☐ Phone Book ☐ Relative ☐ Other _____

Who is the patient's primary care physician? _____

Is the patient a student? If so, list school name _____

Who may we contact in case of emergency? (preferably someone NOT LIVING with the patient)

Name _____ Phone # _____ Relation to Patient _____