PATIENT INFORMATION DATE _____

Name (as on SS card): _____
(FIRST) (M.I.) (LAST)

What do you prefer to be called? _____

Previous Name _____ Gender: Male _____ Female _____

Address: _____
(Street/PO Box) (City) (State/Zip Code)

Home Phone (____)_____ Cell (____)_____ e-mail _____

Preferred Method of Contact: Home / Cell / e-Mail

Birthdate _____/_____/_____

PREFERRED LANGUAGE: _____English _____Spanish Other_____

ETHNICITY: _____ Hispanic or Latino _____Not Hispanic or Non-Latino _____Unknown
_____ I decline to answer

RACE: ____ American Indian or Alaska Native _____ Asian _____ Black or African American
____Native Hawaiian or Other Pacific Islander _____ White _____ Unknown
____ I decline to answer

Employer _____

Employer's Address _____ Phone # _____

Permission to speak about my care on my behalf is granted to:

Name _____ Phone (____)_____

Alternate Notification _____ Phone (____)_____
Relationship: Parent / Grandparent / Son / Daughter / Spouse / Neighbor / Friend / Other

Signature _____

Do you have an Insurance policy that covers hearing aids? _____ Yes _____ No
Example: Amplifon, Clear Value, American hearing benefits

Policy Holder: Name_____ Date of Birth_____/_____/_____

Primary Care Doctor _____ MD/DO/PA/NP _____
(Name) (City/State)

MINOR lives with (names)_____
Relationship: Both Parents / Mother / Father / Guardian / Grandparent

Mother (Name) _____ Father (Name) _____