Karen Kallio, Au.D., CCC/A
Doctor of Audiology

870 Corporate Drive #303
Lexington, KY 40503
859-368-8893

PRIMARY CARE PHYSICIAN:_____

PATIENT INFORMATION:

LAST NAME:_____ FIRST NAME:_____ M.I.:_____

NICKNAME:_____ EMAIL:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

EMPLOYER:_____ WORK PHONE:_____

DOB:_____ SEX:_____ MARITAL STATUS:_____

RACE: ____AMERICAN INDIAN/ALASKAN ____ASIAN ____BLACK ____CAUCASIAN ____OTHER_____

ETHNICITY: ____ HISPANIC or LATINO ____ N/A LANGUAGE:_____

INSURANCE & BILLING INFORMATION:

INSURANCE COMPANY:_____

ID#_____ GROUP#_____

RESPONSIBLE PARTY: ____SELF ____MOTHER ____FATHER ____"OTHER"

EMPLOYER:_____

IF "OTHER" PARTY, PLEASE PROVIDE ADDITIONAL INFORMATION:

INSURED LAST NAME:_____ FIRST NAME:_____ M.I.:_____

RELATIONSHIP TO PATIENT:_____ SEX:_____ DOB:_____

BILLING ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ CELL PHONE:_____

WORK PHONE:_____ EMAIL:_____

EMERGENCY CONTACT INFORMATION

LAST NAME:_____ FIRST NAME:_____ M.I.:_____

RELATIONSHIP TO PATIENT:_____ SEX:_____

HOME PHONE:_____ CELL PHONE:_____

Kallio Audiology & Hearing Care of Lexington
Just Like Family

Karen Kallio, Au.D., CCC/A
Doctor of Audiology

870 Corporate Drive #303
Lexington, KY 40503
859-368-8893

PRIVACY POLICY

By signing below, I acknowledge that I received a copy/read a copy of Kallio Audiology & Hearing Care of Lexington Notice of Privacy Practices. The notice provides information how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

Patient/Guardian Signature:_____ **Date:**_____

PERMISSION FORM

Please list any person(s) who is permitted to receive information relating to your care administered by Kallio Audiology & Hearing Care of Lexington. You have the right to revoke permission at any time by giving a notice in writing by way of fax, through the mail, or in person.

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Name:_____

Relationship:_____