AUDIOLOGISTS NORTHWEST
Recapture the sound around you

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Last name	First Name	Middle Initial	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	Birth date: / /	Age:	Sex: ❑ Male ❑ Female
SSN:	Home phone:		Cell Phone:
Email:	May we email you? ❑ Yes ❑ No		May we Text your Cell phone? ❑ Yes ❑ No
Street address:			
City:	State:	ZIP Code:	
Occupation:	Employer:	Employer phone:	

Referred to clinic by (please check one box):

❑ Dr.
❑ Yellow Pages
❑ Insurance Plan
❑ Hospital
❑ Family
❑ Friend
❑ Close to home/work
❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone number:	Work phone number:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Audiologists Northwest or insurance company to release any information required to process my claims.

Patient/Guardian signature:	*Date:*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

By signing below, I am acknowledging that: I am either the patient or the patient's personal representative; I have received a copy of the "Notice of Privacy Practices" for Audiologists Northwest; and I understand that I may contact the person named in the Notice if I have questions about the content of the Notice

Print:

Patient/Guardian Signature:	*Date:*