|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s Name |   | M / F | Date of Birth |   |
|  Status | ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Legally separated ☐ Child/minor |
| Spouse’s Name |   | (If patient is a minor) father’s name |   | (If patient is a minor) mother’s name |   |
| Street Address |   |
| City |   | State |   | Zip |   |
| Home Phone |   | Cell Phone |   | Work Phone |   |
| Email Address |   |
| Occupation |   | Employer |   |
| Is it ok for us to?(choose **ALL** acceptable options) | ☐ Call | ☐ Leave a Message | ☐ Text | ☐ Email |
| How would you like your appointment reminders? | ☐ Email ☐ Text ☐ Call Which number? |
| How did you hear about us? | ☐Referred by physician ☐ Newspaper Ad ☐ Insurance referral☐ Advertisement/Mailer ☐ Referred by family, friend, patient ☐ Internet ☐ Other  |
| Please provide us with the name of person who referred you so we may thank them |   |
| Emergency/ Alternate Contact |   | Phone |   |
|  Relationship to patient |       |
|   |
| Responsible Party for billing (if other than patient) |   |
| Responsible Party’s (Address) |   |
| Responsible Party’s (city, state, zip) |   | Phone |   |
|   |
| Primary Care Physician Name |   |
| Physician (City & State) |   | Phone |   |
| **Insurance: Please provide insurance cards at the front desk** |
| Primary insurance | Policy # | Group # |
| Secondary insurance | Policy # | Group # |
| Additional Insurance Information – If policy holder is someone other than patient, please complete this section |
| Policy Holder’s Name**PLEASE READ CAREFULLY, AND SIGN BELOW:** This will serve as “Signature-on-File” for any insurance/third party payments made on my account and I hereby authorize the release of any information necessary to provide audiological or medical history to Vail Hearing Healthcare. I also release information necessary to file a claim with my insurance company and assign benefits otherwise payable to VHH. I understand and agree to be personally responsible for the balance and/or deductible as stipulated by my policy. I certify this information is true and correct to the best of my knowledge. I have read all the information on this sheet and hereby give VHH permission to treat my concerns. I also acknowledge that I have received a copy or have been offered a copy or the opportunity to read and review the HIPPA privacy practices of this office and fully accept the agreements made forth in the HIPPA for Vail Hearing Healthcare. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   | Policy Holder’s Birth date |   |