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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | | | | | | | |  | | | | | |