Patient Information

Please present your insurance card(s) and drivers license so a copy may be taken.

Appointment Date:________________

PATIENT INFORMATION

Name:____Sex:M/F
Age:_________Birthdate:____________Social Security #:________________
Parent names (if patient is a child):___________________________________
Marital Status:__________________________Spouse name:_______________
Address:_____________________________Home Phone:__________________
City:_________________State:________Zip:_______ County:_______________
E-Mail Address:____
Employer Name:___________________________Phone:___________________
Employer Address:____
Occupation:____
Referring Doctor:_____________________________City,State______________
Family Doctor: _______________________________City,State______________
Emergency Contact & relationship to patient:__________________________
____
Emergency Contact Phone:____
How did you hear of Buckeye Hearing Health?________________________

RESPONSIBLE PARTY INFORMATION (If different than above)

Name and Birthdate: ____
Responsible party address & phone:____________________________________
____
Responsible party social security #:____________________________________
Employer Name:____

INSURANCE INFORMATION

Primary Insurance:____
Insurance Holder & Relation to patient:_________________________________
Insurance Holder Birthdate:____
Insurance Holder Social Security number:_______________________________
Insurance Holder Employer:____
Secondary Insurance:____
Secondary insurance holder:____

"I consent and authorize the audiologists of Buckeye Hearing Health, LLC to give treatment and care to ___________________________ which she/he/they deem reasonably necessary in conjunction with the purpose of the visit. I hereby authorize and direct my insurance benefits, if any, to be paid directly to Buckeye Hearing Health. I am financially responsible for any non-covered services. I also authorize the release of any medical information acquired in the course of my examination/treatment to my insurance carrier or referring physician."

Patient Signature & Date____

Patient Information

Insured's Signature & Date____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

"By signing below, I consent to Buckeye Hearing Health, LLC to use and disclose my protected health information for the purpose of treatment, payment, and health care operations. The Notice of Privacy Practices provides more detailed information about how protected health information may be used and disclosed. I have the legal right to review the Notice of Privacy Practices before signing this consent. The Notice of Privacy Practices is subject to change. A copy of the revised notice can be obtained by contacting Buckeye Hearing Health, LLC. Written notification must be obtained to revoke this consent, except to the extent that protected health information has already been used or disclosed as cleared by this consent."

Date:____

Patient Name (Please Print):____

Patient Signature:____

Name of person signing this consent & relationship to patient:___________
____

The following individuals are authorized to my protected health information:

Name	Date of Birth	Phone #