Patient Information

Date _____

First Name _____ M.I. _____ Last Name _____

Preferred Name _____ Gender _____ Date of Birth _____ Age _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

What is your preferred method of contact? (*select one*) ☐ Home Phone ☐ Cell Phone ☐ Email

Summer Address (*if different from above*) _____

How were you referred? _____ **Primary Care Physician** _____

Referring Physician (*if different from above*) _____

Employment Status: ☐ Full time ☐ Part time ☐ Self employed ☐ Retired Student: ☐ Yes ☐ No

Employer _____ Occupation _____ School _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Is spouse a patient? ☐ Yes ☐ No

Spouse First Name _____ Spouse M.I. ____ Spouse Last Name _____

Emergency Contact

Name _____ Relationship to Patient _____

Street _____ City _____ State _____ Zip _____

Phone _____ Email Address _____

Primary Insurance

Insurance Company _____

Insured's Relationship to Patient _____

First/Last Name _____ M.I. _____

Date of Birth _____ Gender _____

Employer _____

Secondary Insurance

Insurance Company _____

Insured's Relationship to Patient _____

First/Last Name _____ M.I. _____

Date of Birth _____ Gender _____

Employer _____

☐ **I give permission to Arizona Hearing Specialists, LLC, to release information, verbal and written, contained in my medical record and other related information, to my insurance company, physician, rehab nurse, case manager, attorney, employer, related healthcare providers, manufacturer's, assignees and/or beneficiaries and all other related persons.**

☐ **I acknowledge that I have received and reviewed the Health Insurance Portability and Accountability Act (HIPAA) policy of this office.**

☐ **I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered and/or purchases made.**

☐ **I have read all the information on this sheet and have completed the above answers, certify this information is true and correct to the best of my knowledge and hereby give Arizona Hearing Specialists, LLC, permission to treat my concerns.**

Signature _____ Date _____

Annual Sig _____ Date _____

Annual Sig _____ Date _____

Annual Sig _____ Date _____

Tucson-Northwest
7574 N. La Cholla Blvd.
Tucson, AZ 85741
520.742.2845 ▲ fax 520.742.3881

Tucson-Ventana/Foothills
6969 E. Sunrise Dr., #200
Tucson, AZ 85750
520.742.2845 ▲ fax 520.615.9772

Green Valley
512 E. Whitehouse Canyon Rd., #196
Green Valley, AZ 85614
520.648.3277 ▲ fax 520.399.3874

www.arizonahearing.com