



Mr /Mrs /Ms /Dr /Rev First _____ MI _____ Last _____

Preferred Name _____ Gender M / F

Email Address _____ Date of Birth _____

Street _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Referral Source _____

Employment Status FT / PT / Not Employed / Self / Retired / Active Military

Employer _____ Occupation _____

Marital Status Single / Married / Divorced / Partner / Widow / Legally Separated

Student Status Full / Part-time School _____

Spouse Name _____ Is spouse a patient here? Y / N

Snowbird Address _____

City _____ State _____ Zip _____

Emergency Contact

Name _____ Relationship to Patient _____

Address _____

Phone _____

Responsible Party

Name _____ Relationship to Patient _____

Address _____

Phone _____ Date of Birth _____

Should we bill to the responsible party after insurance? Y / N

Primary Care Physician _____

Address _____

Phone _____

Referring Physician _____

Address _____

Phone _____

Who may we discuss your hearing health information with? Spouse Children Parents

Others: _____
