Northwest Florida ENT

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PATIENT INFORMATION FORM

Patient Name: **Robert** (First) **Smith** (Last) **L.** (MI) D.O.B. **3** (M) / **2** (D) / **1943** (Y)

Mailing Address: **4506 45th WY** (Street) **Mangonia Park** (City) **FL** (State) **33407** (Zip)

Home Phone # **(333) 444-5555** Cell Phone # _____

Work Phone # **(918) 599-7352** SSN: **222-33-2234** Sex: Male

E-Mail: **robert@gmail.com**

Occupation: _____
(If retired, prior occupation)

Marital Status: ____ Married ____ Single

Emergency Contact: **Lisa** Phone #: _____

Relationship to Patient: **Wife**

Primary Care Physician: **Dr. Susan Elwell** Phone #: **(519) 771-1113**

How did you hear about us?

____ Mail ____ Newspaper Ad ____ Promotional Call ____ Radio ____ Insurance

____ Yellow Pages ____ Sponsored Event ____ Health/Senior Fair ____ Website

____ Employer

____ Referred by Friend: _____

____ Referred by Physician: _____

____ Other: _____

INSURANCE INFORMATION
Please give your insurance information to our front office staff so we can make a copy for our records.

Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas.

Location and accessibility ____ Excellent ____ Average ____ Poor

Adequate parking ____ Excellent ____ Average ____ Poor

Convenience of appointment times ____ Excellent ____ Average ____ Poor

Friendly greeting ____ Excellent ____ Average ____ Poor

Clean and welcoming environment ____ Excellent ____ Average ____ Poor

What can we do to make your next visit more comfortable? _____

******** PLEASE READ CAREFULLY AND SIGN BELOW ********

___ I give permission to my AudigyCertified™ Practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

___ I acknowledge that I have received and reviewed the Health Insurance Portability & 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 or purchases rendered.

___ 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 my AudigyCertified Practice permission to treat my concerns.

___ The FDA has determined that it is in my best health interest to have a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing hearing instruments, I have been advised by my AudigyCertified Practice and/or its agents about this determination and hereby waive this requirement.

I have read and understand all the above information.

_____Date: _____

A copy of this signature is as valid as the original.

Signature of Parent or Guardian if patient is a minor:_____

DATA ENTERED BY: _____
(INITIALS)