heidi's hearing
AUDIOLOGY | HEARING AIDS | ASSISTIVE DEVICES

Patient's Name: _____ DOB: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email address: _____

Current Employment: ☐Full-Time ☐Part-Time ☐Retired ☐ Unemployed ☐ Student

PRIMARY CARE PHYSICIAN: _____

Whom may we thank for referring you? _____

Insurance Information

Primary Insurance: _____ Member ID: _____

Insured's Name: _____ DOB: _____ Relationship to insured: _____

Secondary Insurance: _____ Member ID: _____

Insured's Name: _____ DOB: _____ Relationship to insured: _____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Heidi's Hearing Inc a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

_____

Signature of Patient OR Parent/Guardian if patient is a minor **Date**

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Like us on Facebook: Heidi's Hearing, Inc.