HEARING ASSOCIATES OF SOUTH CAROLINA

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HEAR WITH YOU **TOGETHER**

PATIENT INTAKE FORM: PLEASE PRINT

PATIENT'S NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIPCODE)

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

SSN: _____ EMAIL ADDRESS: _____

DATE OF BIRTH: _____ / _____ / _____ GENDER: _____ MALE _____ FEMALE

MARITAL STATUS : _____ M _____ D _____ S _____W SPOUSE'S NAME: _____

EMERGENCY CONTACT: (NAME) _____ (PHONE) _____

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: ____ FULL TIME ____ PART TIME ____ UNEMPLOYED ____ RETIRED

EMPLOYER'S NAME AND ADDRESS: _____

PHYSICIAN INFORMATION

PRIMARY PHYSICIAN: _____

ADDRESS: _____

REFERRING PHYSICIAN (IF APPLICABLE): _____

ADDRESS: _____

HOW DID YOU HEAR ABOUT US?: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By checking this box and signing below, I acknowledge Hearing Associates of South Carolina's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to fully understand the Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

SIGNATURE OF PATIENT OR REPRESENTATIVE: _____ DATE: _____