



PATIENT INTAKE FORM

HEAR WITH YOU TOGETHER

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

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

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 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 RECEIPT OF NOTICE OF PRIVACY PRACTICES

- ☐ By checking this box and signing below, I acknowledge that I received a copy of **Hearing Associates of South Carolina (HASC)'s Notice of Privacy Practices**. The Notice provides information about how HASC may use and disclose the medical information that they maintain about you. HASC encourages you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area and the website and that any revised Notice of Privacy Practices will be made available.

SIGNATURE: _____

DATE: _____