NEW PATIENT CONTACT INFORMATION AND HIPAA CONSENT FORM

Date: ___ /___ /___ Home Phone: __ __ __ - __ __ __ - __ __ __ __ Cell: __ __ __ - __ __ __ -__ __ __ __
Name: ____ Male or Female (circle) Date of Birth: ___ / ___ / ___
Address: ____ City: _________________ State: _____ Zip: ________
Email: ____ Spouse's Name: ________________________________

How did you hear about our practice? ____

Primary Care Information

Physician Name: ___________________________
Practice Name: ____________________________
May we provide your physician with a copy of your hearing health assessment? **Y or N** (circle)
Are you being treated for any medical conditions that may affect your hearing? ___________________________
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HIPAA Compliance Patient Consent Form

May we phone, e-mail, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medial condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____
(Please print name)

Signature: ____ Date: __________________

Relationship to patient: __________________________