THE HEARING CENTER OF CHESTERTOWN

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## Patient Information

Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: __________

Home Phone: __________ Work: __________ Cell: __________

Email address: ____________________ ___ iPhone ____ Android ____Other

Date of Birth: __________ Gender: ___ Male ____ Female

Marital Status: ___ Married ____ Single ____Divorced ____Widowed ____ Long-term commitment

Occupation: __________ Employer: ____________________

Primary Care Physician: ____________________

Physician's address and/or phone #( if not local): ____________________

Spouse's Name: ____________________ Date of Birth: __________

Person Responsible for Payment: ____________________

Address (if different from patient): ____________________

Referral Type: ____________________ Source: ____________________

## Insurance

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

**Please read carefully and sign below.**

I give permission to the Hearing Center of Chestertown 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 been offered the Health Insurance Portability & Accountability Act (HIPAA)compliant privacy policy of this office for review.

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, completed the above answers, and certify this information is true and correct to the best of my knowledge, and I hereby give my hearing care provider permission to treat my concerns.

**X** ____________________ ____________________

Signature of Patient or Parent/Guardian of Patient Date