Cityview Audiology & Hearing Aids, Inc.
7801 Oakmont Blvd. Ste. 109
Fort Worth, TX 76132
817-263-1800

Patient Information Form

Date_____

Patient Name_____DOB ____/____/____
First MI Last

The remainder of this section MUST be completed by someone who is over the age of 18.

Name of Responsible Party_____
First MI Last

Home Phone #_____ Cell Phone #_____

Work Phone # _____ Sex: M F

E-Mail_____

Mailing Address_____
Street City State Zip

Age_____Occupation_____
(If retired, prior occupation)

Marital Status ____Married ____Single ____Widowed ____Divorced ____Long-Term Commitment

Spouse Name_____

Emergency Contact_____Phone # _____

Relation to Patient_____

Primary Care Physician_____Phone # _____

How did you hear about us? _____

____Mail ____Newspaper Ad ____Promotional Call ____Radio ____Insurance

____Yellow Pages ____Sponsored Event _____Health/Senior Fair ____Website ____Employer

____Referred by Friend_____

____Referred by Physican_____

____Other_____

Reason for Appointment_____

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We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous, and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	**_____Excellent**	**_____Average**	**_____Poor**
Adequate parking	**_____Excellent**	**_____Average**	**_____Poor**
Convenience of appointment times	**_____Excellent**	**_____Average**	**_____Poor**
Friendly greeting	**_____Excellent**	**_____Average**	**_____Poor**
Clean and welcoming environment	**_____Excellent**	**_____Average**	**_____Poor**

What can we do to make your next visit more comfortable?

Insurance Information

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 my Audigy Certified practice 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.**

_____Initial to give permission to release records.

- **I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability (HIPPA) policy of this office.**
- **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 hereby give my Audigy Certified practice permission to treat my concerns.**

I have read and understand all the above information.

Patient Signature (A copy of this signature is as valid as the original) **Date**

Signature of Parent or Guardian **Date**

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MEDICATION

Name:_____

Date:_____

Please list current medications. Please include prescription, over-the-counter, herbals, vitamin/mineral/dietary nutritional supplements. Please include drug name, dosage, frequency and route (by mouth, trans-dermal, etc.).

DRUG NAME	DOSAGE	FREQUENCY	ROUTE