Patient Information

Patient name _____ Date _____

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 #_____ Patient's Sex _____

Email Address _____

Mailing Address _____
Street City State ZIP

Age_____ Occupation _____
(If retired, prior occupation)

Marital Status ○ Married ○ Single ○ Widowed ○ Divorced ○ Long-term commitment

Emergency Contact _____ Phone # _____

Relation to Patient _____

Primary Care Physician _____ Phone # _____

How did you hear about us? _____

○ Mail ○ Newspaper Ad ○ Promotional Call ○ Insurance ○ Yellow Pages

○ Sponsored Event ○ Health/Senior Fair ○ Website ○ Employer ○ Radio

○ Referred by Friend _____

○ Referred by Physician _____

○ Other _____

Reason for Appointment _____

CITYVIEW AUDIOLOGY & HEARING AIDS, INC.

Ph • 817.263.1800 | Fx • 817.263.1802
5701 Bryant Irvin Rd, Ste 202
Fort Worth, TX 76132

Patient Information

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

Patient 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

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