AUDIOLOGY ASSOCIATES OF HOLLADAY

Patient Information Form

Chart #: _____ Date: _____

Print Patient Name: _____ DOB: _____

First MI Last MM DD YYYY

If patient is under the age of 18, the responsible party must complete the remainder of this section:

Name of Responsible Party: _____

First MI Last

Home Phone #: _____ Cellphone #: _____

Work Phone #: _____ Patient's SSN #: _____ Sex: ☐ M ☐ F

Email: _____

Mailing Address: _____

Steet City State Zip

Secondary Address: _____

Steet City State Zip

Age: _____ 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 ☐ Yellow Pages ☐ Newspaper Ad ☐ Sponsored Event ☐ Promotional Call

☐ Health/Senior Fair ☐ Radio ☐ Website ☐ Insurance ☐ Employer

☐ Referred by Friend: _____ ☐ Referred by Physician: _____

☐ Other: _____

Reason for Appointment: _____

_____

TURN PAGE OVER →

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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 helpful and 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 Audiology Associates of Holladay 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 health care providers, assignees, beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes.

_____ **Initial to refuse permission to release records**

I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) 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 Audiology Associates of Holladay 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

Roosevelt
58 E. 100 N. (Farm Bureau Ins. Office)

Salt Lake City
1377 E. 3900 S., STE. 201

Vernal
365 W. 50 N., #W10 (Windsor Bldg.)

801.272.1232