WACO Hearing Center

254.878.4040
www.WacoHearingCenter.com

Patient Intake

Date: _____

Patient: _____ _____
Full Name Preferred Name

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Age: _____ Date of Birth: _____ **Please Check:** Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

SS # of Patient: _____ Responsible Party (if minor) Parent/Guardian: _____

Referred by ☐ Friend/family member ☐ Social media ☐ Online search ☐ TV or print ad ☐ Other: _____

Family Doctor (Pediatrician, etc.): _____

Primary Insurance: _____ Patient's Place of Employment: _____

Name of Insured (Insured = **Primary Policy Holder,** e.g., parent, spouse, etc.): _____

Social Security #: _____ Date of Birth: _____ Relation to Patient: _____

Policy #: _____ Group Number: _____

RELEASE OF INFORMATION:**

I hereby authorize members of the staff to release my information to the following. Please check all that apply:

☐ Referring Physician ☐ Spouse ☐ School
☐ Referring Facility ☐ Parent(s) ☐ Employer
☐ Family Doctor ☐ Child(ren) ☐ Insurance Company
☐ Other: _____

The staff may leave a message ☐ voice and/or ☐ text at _____ and/or _____ regarding an appointment or receipt of durable medical equipment.

I give permission to receive newsletters or information about upcoming events and articles pertaining to services or products available from the clinic at ☐ my email address and/or ☐ my street address.

I give permission to my hearing healthcare professional to release information, verbal and written, contained in my medical records and other documents to my insurance company, rehab nurse, case manager, attorney, employer, healthcare providers, assignees and/or beneficiaries and all other relevant persons. Information that does not identify me as the patient may be used for quality purposes.

I acknowledge that I have agreed that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchase made.

I hereby authorize the transfer of my records to be released to Lauren York, Au.D., CCC-A, F-AAA and Waco Hearing Center.

I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge and hereby give my hearing healthcare professional permission to treat my condition.

_____ _____
Signature Date

5016 W. Waco Dr., Waco, TX 76710