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Forms mailed to patient:

- Hearing Health History**
- Dizziness Questionnaire**
- VNG Brochure**
- "Hear the Difference" Brochure**
- Appointment Card**

Date /Time of Appointment _____
Audiologist _____
Type of Appointment _____ Initials _____

NAME: _____
Last Name First Name Middle Init.

ADDRESS: _____
Street City State Zip

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY #: _____

HOME PHONE _____ WORK _____ CELL _____

E-MAIL _____

EMPLOYER _____ OCCUPATION _____ RETIRED FROM: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ Provider or Cust. Svc. Phone #: _____

ID # _____ Group # _____

SECONDARY INSURANCE _____

ID # _____ Group # _____

If bill is to be sent to someone other than patient please provide following information:

NAME _____ SS# _____

ADDRESS _____

PHONE _____ EMPLOYER _____

HOW DID YOU HEAR ABOUT US?

1. ___ **Phone Book**
2. ___ **Our Website**
3. ___ **Friend**
4. ___ **Referral from Physician:**
... **Are they an Ear, Nose & Throat Doctor?** ___ Yes ___ No
... **Doctor's Name** _____
5. ___ **Newspaper**
6. ___ **Verizon Superpages on Internet**
7. ___ **Other** _____