PATIENT INFORMATION SHEET

Last Name		First Name			
Today's Date		Home Phone			
Work Phone		Cell Phone			
How Did You Hear About Us?	□Family member □Internet □Friend □Doctor □Patient □Other: ___________ (Name: ____)				
Address					
City		State		Zip	
Email Address		Date of Birth			
Marital Status		Spouse			
Employer		Occupation			
Emergency Contact		Emergency #			

INSURANCE INFORMATION – We will make a copy of your insurance card(s) and photo ID as required for our records.

Photo ID Verified: Initials _______ Date __________

MEDICAL HISTORY

CURRENT MEDICATIONS : Include supplements, vitamins and over-the-counter medications		
Drug Name	Dosage (mg)	Frequency (how often)

Reviewed by: Initials ________ Date __________

<u>MEDICAL INFORMATION</u> continued for: ____

Primary Care Physician		Phone	
Physician Address			
AUTHORIZATION to communicate regarding your healthcare and treatment. (By checking the box you are authorizing communication with these entities/individuals). Initial here: ___________	□ Primary Care Physician listed □ Other Physician: ___________________ □ Family Member (s): ________________ ________________ □ Other: ____________________________	Phone _________ _________ _________ _________	□ Authorized via voicemail □ Authorized via email □ Authorized via letter
Reason for appointment:			
Tobacco use: □yes □no	If yes what do you use: □Cigarettes □Cigars □Pipe □Smokeless □Other:		
Alcohol use: □yes □no	If yes, how often: □Daily □Weekly □Monthly □Occasionally □Rarely		
Allergies: (food, medications, plastics, etc)	Please list:		

Please check all that apply:

❒	Family Member with Hearing Loss	❒	Dizziness	❒	Vision Problems	❒	Heart Disease
❒	Tinnitus	❒	Right	❒	Left	❒	Both ears
❒	Hypertension	❒	Diabetes				
❒	Hepatitis	Type:					
❒	Head Injury	When					
❒	Cancer	When					
		Treatment:					
❒	Noise Exposure	When					
		Type:					
❒	Other						

By signing below, you allow ***Hearing Solutions in the Triangle, PLLC*** to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges for services rendered. This release is valid for life but may be revoked in writing at any time.

Signature of Patient or Guarantor	Date

Photo ID Verified: Initials ________ Date __________