Parr's Pro Hearing Services Inc.
Hearing and Balance Center
Habersham Medical Center

541 Historic Highway 441-N, Demorest, GA 30535
(706) 839-4050 Fax 1-888-965-9908

PATIENT INTAKE FORM

Welcome to Parr's Pro Hearing Services. Our audiologists are here to provide you with the best hearing and balance care. Please fill out this intake form and the case history form.

How did you hear about us? ____

PERSONAL INFORMATION:

PATIENT'S NAME: ____
FIRST MIDDLE LAST

MAILING ADDRESS: ____
CITY STATE ZIP

TELEPHONE (HOME): ______________________ (CELL): ______________________

BIRTHDATE: __________ AGE: _____ MALE: _____ FEMALE: _____ MARITAL STATUS: _______

NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN: ______________________

NAME AND PHONE NUMBER OF SPOUSE OR NEAREST RELATIVE: ______________________

EMAIL ADDRESS: ______________________ May we contact you via email? YES: ____ NO: ____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER:** As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures.* ***PLEASE INITIAL: __________

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.

If health insurance is not in your name, please provide the following information:

______________________	______________________
Name of insured	Relationship to patient
______________________	______________________
Insured's Date of Birth	Insured's Employer

I hereby authorize Parr's Pro Hearing Services Inc.to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE: ______________________________ DATE: ______________

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔

Send a copy to my physician ______ (initial)

DO NOT send a copy to my physician ______ (initial)

According to HIPAA's Privacy Rule, we are required to make available to you a copy of our Notice of Privacy Practices. Your signature below acknowledges this was offered to you:

SIGNATURE: ______________________________ DATE: ______________