

**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:** _____