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

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?

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PERSONAL INFORMATION:			
PATIENT'S NAME:FIRST			
FIRST	MIDDLE	LAST	
MAILING ADDRESS:	CITY	STATE	ZIP
TELEPHONE (HOME):			
BIRTHDATE: AGE: MALE:			
NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN:			
NAME AND PHONE NUMBER OF SPOUSE OR NEAREST RELATIVE:			
EMAIL ADDRESS:	May we contact yo	u via email? YES:	NO:
INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:			
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: Relationship to patient			
	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:	DA ⁻	E:	_
PLEASE READ AND SIGN/INITIAL:			
In order to keep your medical file up to date, we will audiological findings. <i>Please initial ONE</i> →		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:			

DATE: _____

SIGNATURE: