Patient Demographics

Patient Name: _____ DOB: _____
Parent/Guardian: *(if applicable)* _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Preferred Phone: _____cell home work Alternate: _____ cell home work
Email Address: _____

Emergency Contact: _____ Relationship to Patient: _____
Primary Care Physician: _____ Physician's Practice: _____

Health Insurance
Policy Holder: _____ Policy Holder DOB:_____
Relationship to Patient: _____ Policy Holder SSN:_____

Acknowledgement of Privacy Practices

Please read and initial below:

_____ I certify that the information on this sheet is true and correct to the best of my knowledge. I give KY Hearing Clinic permission to evaluate me.

_____ I acknowledge that I have read a copy of KY Hearing Clinic, LLC Privacy Practices. KY Hearing Clinic, LLC offered me a copy of their Privacy Practices and I declined the offer.

_____ I give KY Hearing Clinic, LLC permission to contact me by telephone, email, and regular mail regarding appointment information, hearing health issues, hearing instruments, and technology. Occasionally, KY Hearing Clinic may contact me regarding marketing for the organization. I understand that I may opt out of communications for marketing at any time. I know that my personal information will not be shared with any other entity.

_____ I give KY Hearing Clinic, LLC permission to leave messages and/or discuss my hearing care products and/or services with the following people:

_____ Answering Machine/Voice Mail

_____ Spouse: _____

_____ Adult Children: _____

_____ Care Giver or Assisted Living Representative: _____

_____ Other: _____

_____ _____
Signature Date

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