Patient Information & Medical History (cont'd on back)

Today's Date:_____ How did you hear about our office? _____

Patient's Name_____
First Middle Last

Mailing Address:_____
Street/PO Box Number City Zip

Home Telephone:_____ Work Telephone:_____

I want to be reminded by text: Yes □ No □ Cell Phone:_____

Email Address: _____

Occupation:_____ Employer:_____

Patient's Date of Birth: _____Social Security Number:_____

Primary Care Doctor:_____
Name Phone

Spouse or Parent: _____
Name Phone

Emergency Contact: _____
Name Relation Phone

Please provide the receptionist with a copy of ALL of your insurance cards.

Noise exposure (circle all that apply):

Firearms Tools Machinery Motorcycles Heavy Equipment Military

Ear history (circle all that apply):

Ear Infections Ear Drainage/Bleeding Ear Pain Ringing/Tinnitus Ear Surgery

Dizziness/Vertigo

I authorize Mendocino Lake Hearing care to release medical information about me to Health Care Financing Administration (HCFA) and it's agents in order to determine if benefits are payable. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay claims. If other health insurance is indicated on approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

I (print name) _____ certify that the above information is true and correct.

Patient's Signature:_____Date:_____