Name ____ Date of Birth _____________ Primary Phone _________________

Address ____ City _______________ State _______ Zip _______________

Cell Phone ______________________ Email Address ____

Retired ? Y N Primary Vocation _______________________

Marital Status: Single Married Widowed Name of Spouse: ____

Nearest Relative or Contact Person: _______________________________________ Phone __________________________

How did you hear about us? Relative/ Friend Physician Newspaper Mail TV Internet
Yellow Pages Magazine Other: ____

Primary Insurance Cardholder: Self Name if other ______________________________ Birth Date _______________

Medical

Primary Physician _____________________________Have you seen your Dr in past year? Y N

Have you seen a Physician specializing in the Ear, Nose or Throat? Y N By whom? _________________________

Recent hearing test? Y N By whom? _____________________When? _____________Results __________________

Do we have permission to send a copy of your results to your physician? Y N

Do You Have Any of the Following Symptoms? Circle all appropriate answers…

Ringing in your ear(s)	Y	N	Rt	Lt	Both	Dizziness	Y	N	
Pain in your ear (s)	Y	N	Rt	Lt	Both	Wax Removal	Y	N	
Drainage from ear(s)	Y	N	Rt	Lt	Both				
Sudden or Rapid Hearing Loss	Y	N	Rt	Lt	Both	Poorer Ear	Rt	Lt	Both

~Initial below at all lines and sign the bottom~

_______I acknowledge that I have been offered to receive the written Notice of Privacy Practices from Rametta Audiology & Hearing Aid Center.

_______I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Rametta Audiology & Hearing Aid Center. A photocopy of my insurance card and a copy of my driver's license are to be considered as valid as an original.

_______ I understand if my insurance pays only a portion of the charges or fails to make payment to Rametta Audiology & Hearing Aid Center within 90 days, I will be responsible for payment in full of the balance at that time.

_______ I give consent to receive testing and treatment from Rametta Audiology & Hearing Aid Center

____ ___________________________

Signature *Relation (if not patient)* *Date*