



C E N T E R

NEW PATIENT INFORMATION RECORD

Please Print!

Patient Name: _____

Age _____ DOB _____ Gender: M F Marital Status: M S W D SEP

Home Tel. # _____ Cell Tel. # _____

Home Address: _____ City: _____ State _____ Zip _____

Employer: _____ Occupation _____ Tel. # _____

Work Address: _____ City: _____ State _____ Zip _____

Name of Spouse (Parent if Minor) _____ DOB _____

Emergency Contact Person _____ Home Tel. # _____ Cell # _____

Primary Insurance Company _____ Tel. # _____

Address: _____ City: _____ State _____ Zip _____

Name of Insured _____ ID# _____ Group # _____

Secondary Insurance Company _____

Address: _____ City: _____ State _____ Zip _____

Name of Insured _____ ID# _____ Group # _____

Regardless of any insurance coverage that you may have, it is your responsibility to pay your bill. Payment is expected when services are rendered, unless other arrangements have been made. We accept cash, check, VISA, Mastercard and Discover.

Primary Care Doctor's Name _____ Tel.# _____

Address: _____ City: _____ State _____ Zip _____

Did anyone refer you here? Y N If yes, who? _____

How did you hear about our office? Newspaper/ Radio Ad Yellow Pages
Friend/ Family Member Other _____

I authorize the release of any medical or other information listed on this form that's necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts the assignment.

Signature _____ Date _____

HEARING/EAR PROBLEMS

Do you currently have any hearing or ear problems? If yes, please be specific: _____

MEDICAL PROBLEMS

Do you have any current health problems? If yes, please tell us briefly: _____

Are you under a physician's care? Yes No

For what? _____

Are you pregnant? Yes No

Do you smoke? Yes No

Please list any medications that you are currently taking:

Please check any of the following which you have had or presently have:

| | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> AIDS/HIV/ARC | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hepatitis A (infectious) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis B (serum) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Allergies/Hives | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve/Bypass | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pain in Jaw |
| <input type="checkbox"/> Venereal Disease | | | |

Are you allergic to any medications or substances? If yes, please list:

Is there any other medical information we should know about?

