



PATIENT INTAKE FORM

Today's Date ____ / ____ / ____

Name _____ DOB ____ / ____ / ____ Age _____

Responsible Party if a Minor _____ Relationship _____

Address _____
Street City State Zip

Cell Phone _____ Home Phone _____

Email _____

How did you learn about our office? _____

Marital Status ☐ Married ☐ Single

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Care Physician _____ Office Location _____

PLEASE READ CAREFULLY AND SIGN BELOW

Primary Insurance _____ Insured's Date of Birth _____

Name of Insured _____ Relationship to Patient _____

Secondary Insurance _____ Insured's Date of Birth _____

Name of Insured _____ Relationship to Patient _____

Records Release and Insurance Payment Authorization

I authorize the release of any medical information necessary to process an insurance claim. I authorize payment of medical benefits to Milwaukee Hearing Center. I have read all of the information above and agree that I am responsible for the balance on my account for all the professional services rendered and products purchased.

Patient Signature (Parent or Guardian if a Minor) Date

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been presented with Milwaukee Hearing Center's Notice of Privacy Practices and that I have been offered a current Notice of Privacy Practices. This notice informs me of how Milwaukee Hearing Center will use my health information for the purposes of treatment and/or payment. This notice explains how Milwaukee Hearing Center may share my health information. Milwaukee Hearing Center will also use and share my health information as required/ permitted by law.

Patient Signature (Parent or Guardian if a Minor) Date

HIPAA Consent to Leave Voicemail/Messages:

I do ☐ I do not ☐ give permission for relevant medical information to be left on my voicemail.

I do ☐ I do not ☐ want relevant medical information shared with the person who may answer the phone.

Please DO NOT (check all that apply):

☐ Email ☐ Text ☐ Mail

The names of individual(s) with whom you may leave pertinent information are (list): _____

Patient Signature (Parent or Guardian if a Minor) Date