COLUMBINE AUDIOLOGY INC.
Helping You Hear Life

Patient Intake Form

Patient Name _____ Sex ☐ M ☐ F Date ___ / ___ / ___
First Last MI MM DD YYYY

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email _____ SSN _____

Date of Birth _____ Marital Status ☐ Married ☐ Single

Emergency Contact _____ Phone _____

Relationship to Patient _____

Primary Care Physician _____ Phone _____

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient _____
☐ Advertisement ☐ Insurance ☐ Referred by Physician _____
☐ Consumer Seminar ☐ Employer ☐ Other _____

PLEASE READ CAREFULLY, CHECK THE BOXES AND SIGN BELOW

☐ I agree I am ultimately responsible for the balance of my account for services rendered.

☐ I acknowledge I have received the Health Insurance Portability and Accountability Act policy for this office.

☐ I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, healthcare providers, employers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

☐ The FDA has determined it is in my best interest to have a medical evaluation by a licensed physician (preferrably a physician who specializes in diseases of the ear) before purchasing hearing devices. I have been advised by the practice and/or its agents about this determination and hereby waive this requirement.

☐ I give permission to receive newsletters or information about upcoming events, specials, and articles pertaining to services or products in the clinic.

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

I have read, understand and agree to the above information.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian if Patient is a Minor Date