Pacific Northwest Audiology

Adult Patient Information

Date _____ File#_____

Patient Name _____ Preferred Name _____
Last First M.I.

D.O.B. _____ Male ☐ Female ☐ I live with _____ or alone ☐

Mailing Address _____
Street City State Zip Code

Preferred Phone Number _____ (Cell / Home) Email Address _____

Permission to Communicate via Email (Medical Reports, Invoices, Appointments) Yes ☐ No ☐

Permission to Communicate via Email (Educational Seminars, Special Events) Yes ☐ No ☐

Marital Status Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

Employment Yes ☐ No ☐ Part-time ☐ Self-employed ☐ Retired ☐ Student Yes ☐ No ☐

Current Employer _____

Referred By _____

Primary Care Physician & Clinic _____ Phone _____

Permission to Send Medical Records / Reports to Your PCP or Other Medical Providers Yes ☐ No ☐

Emergency Contact _____ Relationship to Patient _____

Phone _____ Email _____

Power of Attorney _____ Relationship to Patient _____

Phone _____ Email _____

Insurance _____ ID# _____ Phone _____

Subscriber _____ D.O.B._____ Relation _____

Supplemental / Secondary Insurance _____ Phone _____

Acknowledgement of Receipt of the Notice of Privacy Practices Yes ☐ No ☐

Acknowledgement, Consent & Authorization

I hereby authorize Pacific Northwest Audiology LLC to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Pacific Northwest Audiology and I am financially responsible for any unpaid balance.

Signature of Patient or Guardian _____ **Date** _____

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